WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
Coden USA: WJPRAP Impact Factor 8.63
Volume 15, Issue 7, 138-154. Review Article ISSN 2277–7105

COMMUNITY-BASED APPROACHES TO CERVICAL SPONDYLOSIS: INTEGRATING HOMOEOPATHY INTO PRIMARY MUSCULOSKELETAL CARE

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Article Received on 26 Feb. 2026,
Article Revised on 18 March 2026,
Article Published on 01 April 2026

https://doi.org/10.5281/zenodo.19325784

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How to cite this Article: Dr. Don J. Scott Berin G MD(Hom)*[1], Dr. J. Ashok BHMS, MD(HOM)[2] (2026). Community-Based Approaches to Cervical Spondylosis: Integrating Homoeopathy Into Primary Musculoskeletal Care. World Journal of Pharmaceutical Research, 15(7), 138–154.

ABSTRACT

Cervical spondylosis, a common degenerative disorder of the cervical spine, poses a significant burden on elderly and sedentary populations, affecting daily functioning and quality of life. This review synthesizes evidence from peer-reviewed literature and clinical guidelines to evaluate the role of Homoeopathy in its management. Findings suggest that individualized remedies, alongside community-level education and interventions, may alleviate symptoms, reduce recurrence, and enhance functional outcomes. Homoeopathy's holistic approach, addressing both physical and emotional dimensions, aligns well with community-based healthcare models, offering a sustainable strategy for managing chronic musculoskeletal conditions.

KEYWORDS: Cervical Spondylosis, Community Medicine, Homoeopathy, Musculoskeletal Disorders, Primary Care, Public Health.

INTRODUCTION

Cervical spondylosis is a degenerative condition affecting the cervical spine, with a high prevalence in individuals above 40 years of age. In India, studies report a rising trend due to

poor posture, sedentary jobs, and lack of ergonomic awareness. From a **community medicine** standpoint, this condition reduces productivity, increases healthcare costs, and affects the quality of life, especially in underserved populations.

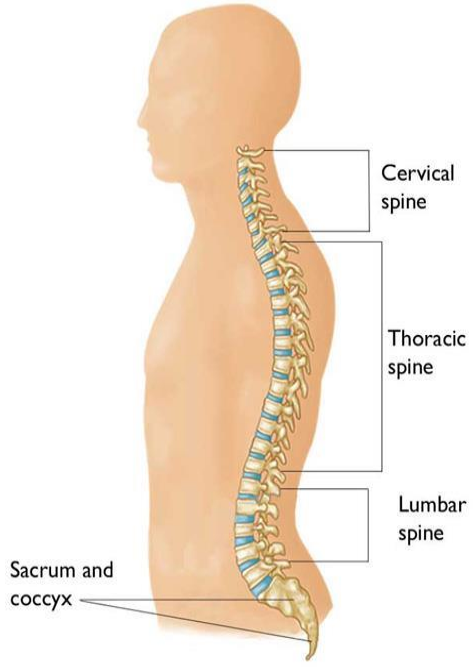
Homoeopathy, a system of individualized medicine, offers potential for inclusion in **primary health care models**, especially in resource-constrained community settings. This paper presents a review-based analysis on how homoeopathy can be integrated into community-based cervical spondylosis care.

Incidence: 85 percent of people over the age of 60 are affected.
Sex: It is common in females than in males.

Anatomy

Spine is made up of 24 bones, called vertebrae, that are stacked on top of one another. These bones connect to create a canal that protects the spinal cord.

The seven small vertebrae that begin at the base of the skull and form the neck comprise the cervical spine.



Cervical spondylosis occurs in the cervical spine—the seven small vertebrae that form the neck.

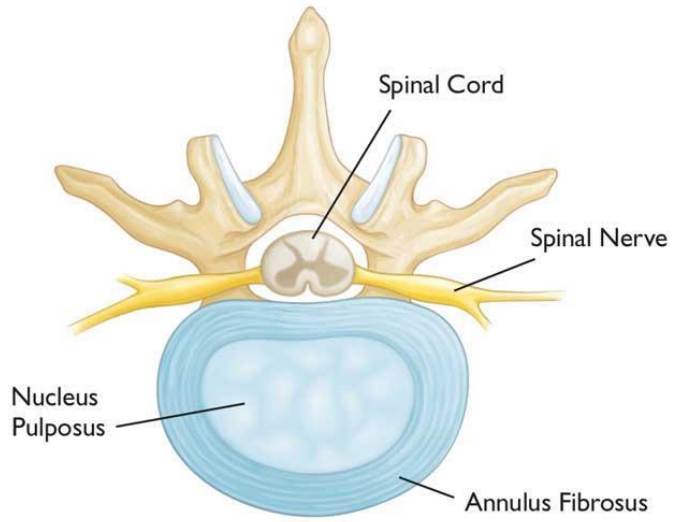
Other parts of your spine include: Spinal cord and nerves. These "electrical" cables travel through the spinal canal carrying messages between your brain and muscles. Nerve roots branch out from the spinal cord through openings in the vertebrae (foramen).

Spinal nerve root

Intervertebral disks. In between your vertebrae are flexible intervertebral disks. They act as shock absorbers when you walk or run.

Intervertebral disks are flat and round and about a half inch thick. They are made up of two components

- **Annulus fibrosus.** This is the tough, flexible outer ring of the disk.
- **Nucleus pulposus.** This is the soft, jelly-like center of the disk.



A healthy intervertebral disk (cross-section view).

Etiology

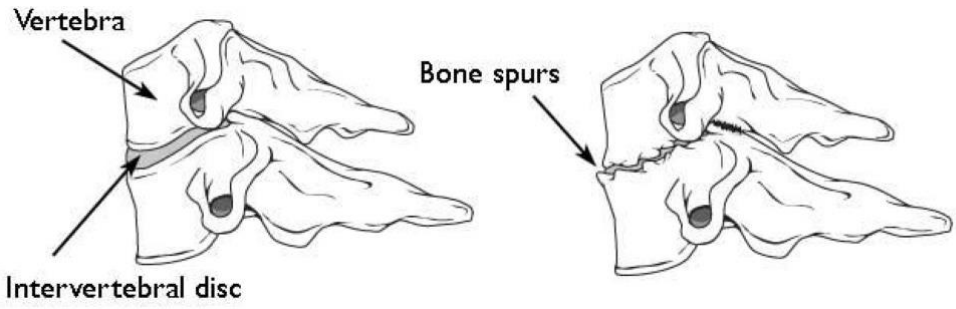
Cervical spondylosis arises from degenerative changes that occur in the spine as we age. These changes are normal and they occur in everyone. In fact, nearly half of all people middle-aged and older have worn disks that do not cause painful symptoms.

Disk Degeneration and Bone Spurs

As the disks in the spine age, they lose height and begin to bulge. They also lose water content, begin to dry out and weaken. This problem causes settling, or collapse, of the disk spaces and loss of disk space height.

As the facet joints experience increased pressure, they also begin to degenerate and develop arthritis, similar to what may occur in the hip or knee joint. The smooth, slippery articular cartilage that covers and protects the joints wears away.

If the cartilage wears away completely, it can result in bone rubbing on bone. To make up for the lost cartilage, your body may respond by growing new bone in your facet joints to help support the vertebrae. Over time, this bone overgrowth — called bone spurs — may narrow the space for the nerves and spinal cord to pass through (stenosis).

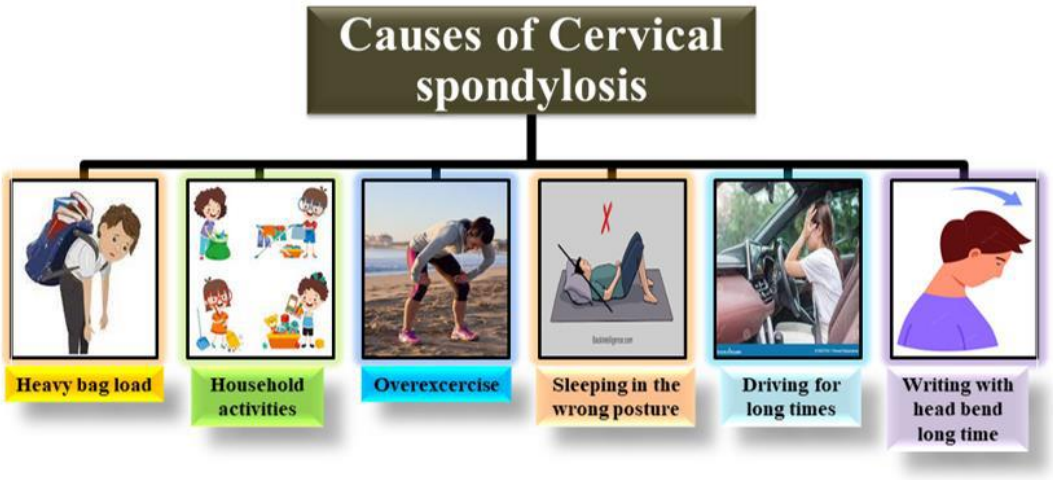


(Left) Side view of a healthy cervical vertebra and disk. **(Right)** A disk that has degenerated and collapsed.

Risk Factors

Age is the most common risk factor for cervical spondylosis. The condition is extremely common in patients who are middle-aged and older.

Other factors that may increase your risk for developing cervical spondylosis and neck pain include



- Genetics—a family history of neck pain and spondylosis
- Smoking—clearly linked to increased neck pain
- Occupation—jobs with lots of repetitive neck motion and overhead work
- Depression or anxiety
- Previous injury or trauma to the neck

Epidemiology

Kelly et al summarized epidemiology studies

"Evidence of spondylotic change is frequently found in many asymptomatic adults, with 25% of adults under the age of 40, 50% of adults over the age of 40, and 85% of adults over the age of 60 showing some evidence of disc degeneration. Another study of asymptomatic adults showed significant degenerative changes at 1 or more levels in 70% of women and 95% of men at age 65 and 60. The most common evidence of degeneration is found at C5-6 followed by C6-7 and C4-5".

Age, gender and occupation are the risk factors for having cervical spondylosis[1]. The prevalence of cervical spondylosis is similar for both sexes, although the degree of severity is greater for males. Although ageing is the major risk factor that contributes to the onset of cervical spondylosis, repeated occupational trauma may contribute to the development of cervical spondylosis. An increased incidence has been noted in patients who carried heavy loads on their heads or shoulders, dancers, gymnasts, and in patients with spasmodic torticollis, although this cause is not widely accepted. In about 10% of patients, cervical spondylosis is due to congenital bony anomalies, blocked vertebrae, malformed laminae that place undue stress on adjacent intervertebral discs.

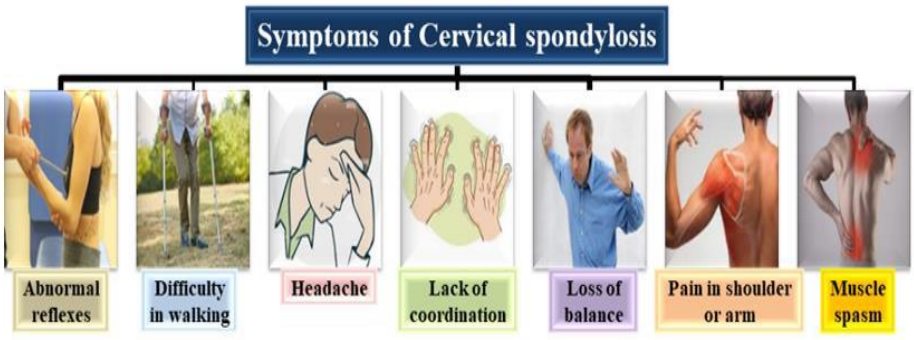
Pathogenesis: Cervical spondylosis is a generalized disease process affecting all levels of the cervical spine. Cervical spondylosis encompasses a sequence of degenerative changes in the intervertebral discs, osteophytosis of the vertebral bodies, hypertrophy of the facets and laminal arches, and ligamentous and segmental instability. The natural history of cervical spondylosis is associated with the aging process. Senescent and pathologic processes are thus morphologically indistinguishable. Clinical manifestations of cervical spondylosis may arise when morphologic sequelae are superimposed on a developmentally narrow spinal canal. The two clinical syndromes of spondylotic radiculopathy and myelopathy are distinct, yet they may overlap.

Clinical features

For most people, cervical spondylosis causes no symptoms. When symptoms do occur, they typically include pain and stiffness in the neck. This pain can range from mild to severe. It is sometimes worsened by looking up or looking down for a long time, or by activities in which the neck is held in the same position for a prolonged period of time—such as driving or reading a book. The pain usually improves with rest or lying down.

Other symptoms may include

1. Headaches
2. Grinding or popping noise or sensation when you turn your neck
3. In some cases, cervical spondylosis results in a narrowing of the space needed for the spinal cord or nerve roots. If this occurs, your symptoms may include numbness and weakness in the arms, hands, and fingers.
4. Trouble walking, loss of balance, or weakness in the hands or legs
5. Muscle spasms in the neck and shoulders.



Cervical spondylosis presents in three symptomatic forms as

1. Non-specific neck pain - pain localised to the spinal column.
2. Cervical radiculopathy - complaints in a dermatomal or myotomal distribution often occurring in the arms. May be numbness, pain or loss of function.
3. Cervical myelopathy - a cluster of complaints and findings due to intrinsic damage to the spinal cord itself. Numbness, coordination and gait issues, grip weakness and bowel and bladder complaints with associated physical findings may be reported.

Symptoms can depend on the stage of the pathological process and the site of neural compression. Diagnostic imaging may show spondylosis, but the patient may be asymptomatic and vice versa. Many people over 30 show similar abnormalities on plain

radiographs of the cervical spine, so the boundary between normal ageing and disease is difficult to define.

Pain is the most commonly reported symptom. *McCormack et al* reported that intermittent neck and shoulder pain is the most common syndrome seen in clinical practice. With cervical radiculopathy the pain most often occurs in the cervical region, the upper limb, shoulder, and/or interscapular region. In some cases the pain may be atypical and manifest as chest or breast pain, although it is most frequently present in the upper limbs and the neck. Chronic suboccipital headache could also be a clinical syndrome in patients with cervical spondylosis, which may radiate to the base of the neck and the vertex of the skull. Paraesthesia or muscle weakness, or a combination of these are often reported and indicate radiculopathy. Central cord syndrome may also be seen in relation to cervical spondylosis and in some cases dysphagia or airway dysfunction have been reported.

Differential Diagnosis

- Other non-specific neck pain lesions - acute neck strain, postural neck ache or Whiplash
- Fibromyalgia and psychogenic neck pain
- Mechanical lesions - disc prolapse or diffuse idiopathic skeletal hyperostosis
- Inflammatory disease - Rheumatoid arthritis, Ankylosing spondylitis or Polymyalgia rheumatica
- Metabolic diseases - Paget's disease, osteoporosis, gout or pseudo-gout, Infections - osteomyelitis or tuberculosis
- Malignancy - primary tumours, secondary deposits or myeloma.

Diagnostic Procedures

Cervical spondylosis is often diagnosed on clinical signs and symptoms alone

Signs

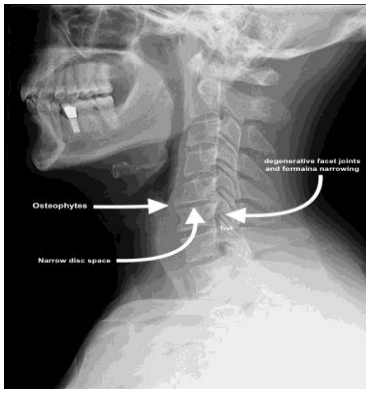
- Poorly localised tenderness
- Limited range of motion
- Minor neurological changes (unless complicated by myelopathy or radiculopathy)

Symptoms

- Cervical pain aggravated by movement
- Referred pain (occiput, between the shoulder blades, upper limbs)

- Retro-orbital or temporal pain
- Cervical stiffness
- Vague numbness, tingling or weakness in upper limbs
- Dizzyness or vertigo
- Poor balance
- Rarely, syncope, triggers migraine.

Most patients do not need further investigation and the diagnosis is made on clinical grounds alone however, diagnostic imaging such as X-ray, CT, MRI, and EMG can be used to confirm a diagnosis.



Plain radiographs of the cervical spine may show a loss of normal cervical lordosis, suggesting muscle spasm, but most other features of degenerative disease are found in asymptomatic people and correlate poorly with clinical symptoms. It is important to realise that radiological changes with age only represent structural changes in the vertebrae, but such changes do not necessarily cause symptoms. It is believed that this mismatch between radiographic appearance and clinical symptoms is not only because of age, but also because of gender, race, ethnic group, height and occupation.

MRI of the cervical spine is the investigation of choice if more serious pathology is suspected, as it gives detailed information about the spinal cord, bones, discs, and soft tissue structures. However, normal people can show important pathological abnormalities on imaging so scans need to be interpreted with care.

Examination

Muscle atrophy is assessed on the affected side in the upper limb, shoulders and scapular regions and compared with the unaffected side. Muscle strength is tested in 4 muscles

representing the myotomes C5-C8. Anterior, middle, and posterior parts of the deltoid muscle are tested by resisting flexion, abduction, and extension of the humerus. Strength of biceps brachii is assessed by resisted elbow flexion when the forearm is supinated. Triceps brachii muscle strength is tested by resisted elbow extension from 90 degrees of elbow flexion. The dorsal interosseus muscles are tested by resisting the separation of the 2nd through 5th fingers. Sensitivity to light touch and to pain are also tested for the relevant cervical dermatomes.

REVIEW OF LITERATURE

Yanwei Lv et al. (2018) conducted a community-based cross-sectional study in six Chinese communities to assess the prevalence and associated factors of symptomatic cervical spondylosis. Among 3859 adults, the overall prevalence was 13.76%, with higher rates in suburban areas (15.97%) and females. Key associated factors included mental work, high housework intensity, and inadequate sleep (<7 hrs/day). Limitations included the cross-sectional design and unmeasured confounding variables, with data dating back to 2010.

Yakshi Bhardwaj et al. (2017) examined neck pain and associated disability in 500 computer users aged 18–25 years. Using the Visual Analog Scale (VAS) and Neck Disability Index (NDI), 99.2% reported neck pain, and 65.8% experienced disability. The study highlights the high prevalence of neck-related impairment among young adults due to prolonged computer use.

Burden of Cervical Spondylosis in the Community

According to WHO's 2022 Musculoskeletal Health Report, neck pain from degenerative causes is among the top 10 reasons for disability worldwide. In India, rural populations face increased risks due to hard labor and limited access to rehabilitative services (WHO, 2022).

The **National Programme for Health Care of the Elderly (NPHCE)** recognizes cervical spondylosis as a growing concern among India's elderly. Yet, pain management remains under-addressed at the primary level.

Scope of Homoeopathy in Community Musculoskeletal Health

Homoeopathy's principles of *similia similibus curentur*, individualization, and holistic treatment make it suitable for chronic conditions like cervical spondylosis. Its low cost, minimal side effects, and adaptability to **community health outreach** make it ideal for **integrative care models**.

Field-Based Interventions

Community-based outreach clinics using **Rhus toxicodendron, Bryonia alba**, and **Kalmia latifolia** have shown effective control of symptoms. Health camps reported improvement in neck mobility, reduced analgesic dependency, and better self-care practices.

Specific advice: Rest and splinting, exercise, hydrotherapy.

Management principles: Give patient education, support, and appropriate reassurance. Referral to physiotherapist and occupational therapists.

Nutrition: Well-balanced high protein, vitamin – D, calcium food and easily digestible diet.

Medical Management

Cervical spondylosis is more often seen as a non-progressive chronic condition and most of the related conditions follow a benign course and may be treated with supportive, symptomatic care. Initial management should be nonoperative, only in rare cases is surgery required.

HOMOEOPATHIC MANAGEMENT

Therapeutic aim: ***Achieve remission, control disease activity, preserve joint function, maintain muscle strength.***

Miasmatic cleavage: The 3 basic miasms psora, sycosis and syphilis either independently or in combination act as fundamental cause. Cervical spondylosis start with psora, followed by sycotic and progress with degenerative changes and finally ends in syphilis.

Homoeopathic medicines for cervical spondylosis

1) Rhus tox – Rhus tox is the most commonly used medicine for cervical spondylosis. The common symptoms on which it is prescribed are pain and stiffness of the part. The pain is generally aggravated by first motion, lying posture, cold damp atmosphere and relieve by any warm application. The others symptoms are numbness or tingling sensation in the arms. Generally the pain is more aggravated in the damp cold weather. Keeping the arm in rest position makes feel the person more pain, but movement does not have. If those are the symptoms then rhus tox will help.

2) Cimicifuga- Cimicifuga or Actea Racemosa is generally prescribed when there is pain in the neck portion from over use of fingers like those who types in computer key pads long

hours with a odd posture, those who plays piano boards long hours, those who stitch or knit hour together. There is more pain in the neck portion when the patient bend his forward or bowing of head. The pain and stiffness are more in the shoulder areas

3) Rananculus bulbous- The pain is felt over the neck portion and sometimes spread downwards and chest portion too. There is more pain during the morning hours and any sort of movement aggravates the pain. Moving the head also causes pain even a deep breathing increases the pain. The pain is associates with numbness feeling of arms. Like cimicifuga the pain is also originated after a long time of writing on laptop key board, I-pad, or mobile.

4) Kalmia- It is one of the most important medicine for cervical spondylosis when the pain is associated with numbness of the part. Here the pain origin at the neck portion and spread down wards to arm and fingers. The pain comes in paroxysmal way not like dull persisting pain found in Rhus tox. There is another important symptoms found in kalmia of vertigo or dizziness while looking downwards.

5) Colocynth- There is pain in the cervical or neck portion which is very much relieved by pressure or massage on that area. The characteristic symptom in colocynth to prescribe in cervical spondylosis is pain arise after some emotional disturbances like getting anger or being offended that impact in his sentiment or suppression of the anger. Those play a trigger factor to start neck pain.

6) Calcarea phos- Calcarea phos is the remedy generally prescribed when there is any osteophytes growth on the vertebral portion due to osteoarthritis changes. Pain is more during a damp humid weather. Along with clcarea phos the calcarea flour also helpful in bony changes of cervical vertebrates.

7) Bryonia Alba- Bryonia Alba is another majorly indicated medicine for cervical spondylosis. The person needing Bryonia Alba experiences pain and stiffness in the neck that worsen with motion. Taking rest relieves the symptoms.

8) Hypericum Perforatum- In addition to Rhus Tox, Hypericum Perforatum is a very significant medicine for cervical spondylosis resulting from an injury. Major symptoms deciding on Hypericum Perforatum as the best prescription are neck pain that may radiate to the shoulders and a spine that is extremely sensitive to the touch. Tingling, burning, numbness in hands may also be present.

9) Paris Quadrifolia- Paris Quadrifolia is an excellent choice of medicine for cervical spondylosis cases with marked numbness in arms, hands or fingers as the major complaint. Pain in the neck is also present. Pain radiates down the fingers from the neck. The pain is attended by the sensation of a heavy weight around the neck and shoulders.

10) Silicea- Silicea is one of the majorly indicated medicines for cervical spondylosis where pain from the neck radiates upwards to the head. Pain from the neck extends to either the occiput (back of the head) or the entire head. In some cases, the neck pain radiates to the head and settles over the eyes. This may be accompanied by vertigo in some cases. Vertigo mainly arises from looking upwards.

Therapeutics according to the views of different authors on cervical spondylosis

'**The Homoeopathic domestic physician' - by Constantine Hering** mentioned that, if lifting or carrying heavy loads or any sudden exertion produces pain, give Rhus tox. Bryonia is indicated when pain is <on any motion. If both these drugs do not relieve entirely, try Sulphur. If headache ensues and Rhus tox will not remove it, then give Calcaria carb.

Dr GHG Jhar in his book 'the therapeutic guide. The most important result of more than 40 years of practice'-mentions drug like Acon, Bry, Bell, Kali carb. And Lach for spinal irritation attended with painful rigidity of nape of neck. If the neck at the same time twisted, he suggested Caust, Calc and ARS alb.

'Practical homoeopathic therapeutic' by W.A Dewey has given importance to the following medicines. Colchicum, Ledum, AMM phos, Anti crud, Lyco, Picric acid and Rhododendron for arthritis. Phos, Calc carb and silicea for syphilitic carries of vertebrae. Phosphoric acid for carries of spine. Actea, Sulphur, Bell, Gels, Nat mur, Puls, Agar, Zinc, Phos, Cocculus, Nux vom, Oxalic acid, Kali carb etc for spinal affections.

Dr. Richard Hughes in his book 'a manual of pharmacodynamics' suggested Aconite, Actea racemosa, Bry, Colch and Dulc for stiffneck.

'Quick bed side prescriber' proposes Lach 200 for spondylitis i.e.-inflammation of vertebrae. Mag phos 30, Kali mur 30 and Calc fl 30X are also important.

Aconite, Bell, Chamomilla, Kalm, Colocynth, Merc, Spig, Ars, Bry, Caust, Lyco, Mezerium, Nux vom, Phos, and Puls are mentioned in the book '**the outine of materia medica'.by Henry Buck for neuralgia 'Knowledge of the physician' by Richard Hughes** considered

Aconite, Kalm, Bry, Propylamine, Rhus tox, Dulc, Rhodo, Spig, Actea, Ledum, Merc, Phyto and Sulph for neck pain.

Drug like Acon, Bry, Cepa, Hyper, kalm, Paris, Phyto, Rhus tox, Merc and Tereb are mentioned for brachial neuralgia in the book 'realistic materia medica with therapeutic hints'.

Integrating Homoeopathy into Primary Care: A Community Model

A **community-oriented framework** includes

- **Awareness Camps:** Educating about posture, ergonomics, and homoeopathy.
- **Mobile Clinics:** Providing Homoeopathic care in rural and tribal areas.
- **Training of Health Workers:** Integrating Homoeopathy into ASHA and PHC worker training.
- **Referral Systems:** Linking community cases with higher centers for diagnostic support.

This model aligns with **Primary Health Care (PHC)** and **Ayushman Bharat** strategies, promoting **integrative healthcare delivery**.

DISCUSSION

Incorporating Homoeopathy in community settings is feasible and potentially transformative, especially in musculoskeletal disorders like cervical spondylosis. Homoeopathy reduces reliance on pharmaceuticals, empowers local health workers, and strengthens **preventive and promotive care**. However, challenges include the need for RCTs, policy-level integration, and public awareness.

CONCLUSION

Cervical spondylosis, as a degenerative condition of the cervical spine, poses a growing burden on public health systems, especially in aging populations and among individuals with sedentary lifestyles. Conventional therapies provide temporary relief but often fail to address the chronic nature and recurrence of the condition. Homoeopathy, when integrated into community medicine, offers a holistic, cost-effective, and patient-centered alternative. Its focus on individualized care and minimal side effects makes it well-suited for long-term management at the grassroots level. Combined with lifestyle modifications and health education, homoeopathic treatment can play a vital role in improving functional outcomes and quality of life. Strengthening its presence within national programs like the National Programme for Health Care of the Elderly (NPHCE) can enhance the reach and effectiveness of primary care services. With further research and policy integration, Homoeopathy can

contribute significantly to sustainable management of musculoskeletal conditions like cervical spondylosis.

ACKNOWLEDGEMENT

I express my heartfelt gratitude to my most esteemed **Dr. J. Ashok, BHMS, MD (Hom)**, Head of the Department of Forensic Medicine and Toxicology, Government Homoeopathic Medical College and Hospital, Tirumangalam, Madurai. His unwavering support, insightful guidance, and constant encouragement throughout my postgraduate journey have been a profound source of inspiration. His dedication to academic excellence and patient-centered Homoeopathic practice continues to shape my vision and commitment toward integrative primary care. This review article is a humble tribute to his noble influence and mentorship.

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