

Non-Surgical Resolution of Acute Appendicitis Under Individualised Homoeopathic Care: A Case Report

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Conflicts of Interest: Nil

Abstract

Acute appendicitis is a common surgical emergency, and appendectomy remains the standard of care in most settings. In carefully selected, clinically stable patients without signs of perforation or sepsis, non-operative strategies such as antibiotic-first approaches are increasingly discussed, although recurrence and delayed complications remain important concerns. This report describes a 32-year-old male with imaging-confirmed uncomplicated acute appendicitis who refused surgery and conventional medication and opted for exclusive homoeopathic management under close monitoring but with clear safety instructions regarding urgent referral for imaging or surgical intervention if the pain worsened or fever or vomiting persists.

He presented with migratory abdominal pain localised to the right iliac fossa, low-grade fever, nausea, vomiting and loss of appetite; ultrasonography showed an inflamed, non-compressible appendix measuring 12–13 mm with periappendiceal echogenic mesentery, and C-reactive protein (CRP) was 47.1 mg/L while total leukocyte count remained within the reference range. After detailed counselling about standard care, potential risks and red-flag symptoms, an individualised homoeopathic regimen was initiated: *Lycopodium clavatum* 1M single dose, followed by *Belladonna* 200 and *Iris tenax* 30, along with supportive dietary and lifestyle advice.

The patient felt slightly better after the single dose of *Lycopodium clavatum* 1M, and with subsequent *Belladonna* 200 and *Iris tenax* 30, symptoms resolved within about one week, followed by progressive objective improvement on serial investigations documented over subsequent follow-up. Pain and tenderness decreased within 24–48 hours, the patient resumed routine activities by the end of the month, serial ultrasonography demonstrated progressive reduction of appendiceal diameter to about 5 mm with disappearance of inflammatory changes, and C-Reactive Protein (CRP) normalized within six weeks. The case is structured in accordance with Case Report (CARE) and Homoeopathic Clinical Case Reports (HOM-CASE) reporting guidelines and includes Alvarado, Appendicitis Inflammatory Response (AIR), and

Modified NARanjo Criteria for Homoeopathy (MONARCH) based assessment to improve transparency and authenticity of clinical documentation.

Keywords: Acute Appendicitis, Homoeopathy, Ultrasonography, Care, Hom-Case, Monarch

Introduction

Acute appendicitis is a disorder characterized by acute inflammation to the vermiform appendix caused by a pathogenic agent. It is one of the leading causes of acute abdominal pain worldwide and is a surgical emergency condition with a lifetime risk of around 7-9%. Though no age is exempt but it is rare before the age of 2 years and the peak incidence is in the second and third decades of life. Diagnosis is based on a combination of history, focused physical examination, laboratory markers and imaging, while clinical scoring systems such as the Alvarado score and AIR score are used to support diagnostic risk stratification, particularly in confusing presentations. Appendectomy is still regarded as the standard treatment, especially when perforation, abscess, generalized peritonitis or sepsis are suspected.^{1-5,11}

In selected patients with uncomplicated appendicitis, non-operative approaches have been evaluated, most commonly antibiotic-first treatment, although recurrence and treatment failure remain important limitations. Within homoeopathic literature, case reports have described non-surgical management of appendiceal inflammation, but many older reports lack structured reporting standards, objective outcome assessment and formal causal attribution. The CARE guideline, the HOM-CASE extension and MONARCH helps in improving the transparency and scientific value in such reports.⁶⁻¹⁰

This case report presents an adult male with imaging-confirmed early uncomplicated acute appendicitis who refused surgery and was managed under individualized homoeopathic care with close follow-up but with clear safety instructions regarding urgent referral for imaging or surgical intervention if the pain worsened or fever or vomiting persists. The report also incorporates standard appendicitis scoring systems and structured MONARCH assessment to strengthen methodological clarity.

Case Report

Patient Information

A 32-year-old male businessman, normotensive and non-diabetic, presented with dull aching abdominal pain localised to the right iliac fossa, nausea, vomiting and loss of appetite for three days. The pain began around the umbilicus and then shifted to the right iliac fossa, and was associated with low-grade fever. He reported occasional constipation but no history of previous abdominal surgery, inflammatory bowel disease or chronic gastrointestinal complaints. There was no family history of appendicitis or other inflammatory bowel conditions.

He was not taking regular allopathic medication, had no known drug allergies and denied tobacco, alcohol or recreational drug use. His main reason for seeking homoeopathic care was to avoid surgery. Written informed consent was obtained from the patient for publication of this anonymised case report, including clinical data and imaging findings

Clinical Findings

At presentation he was anxious but haemodynamically stable, with temperature 99.9°F, pulse 100/min, blood pressure 128/90 mmHg and respiratory rate 18/min. Abdominal examination showed localized tenderness and guarding in the right

iliac fossa, maximal at McBurney's point, with rebound tenderness and a positive Rovsing's sign; there were no signs of generalized peritonitis. Cardiovascular, respiratory and neurological examinations were otherwise unremarkable.

Diagnostic Assessment

Baseline investigations dated 9 February 2026 showed total leukocyte count 9,900/ μ L with 60% neutrophils, normal haemoglobin and platelet counts, and high-sensitivity CRP 47.1 mg/L, indicating marked systemic inflammation. Liver and renal function parameters were largely within acceptable limits except for mildly raised aspartate aminotransferase.

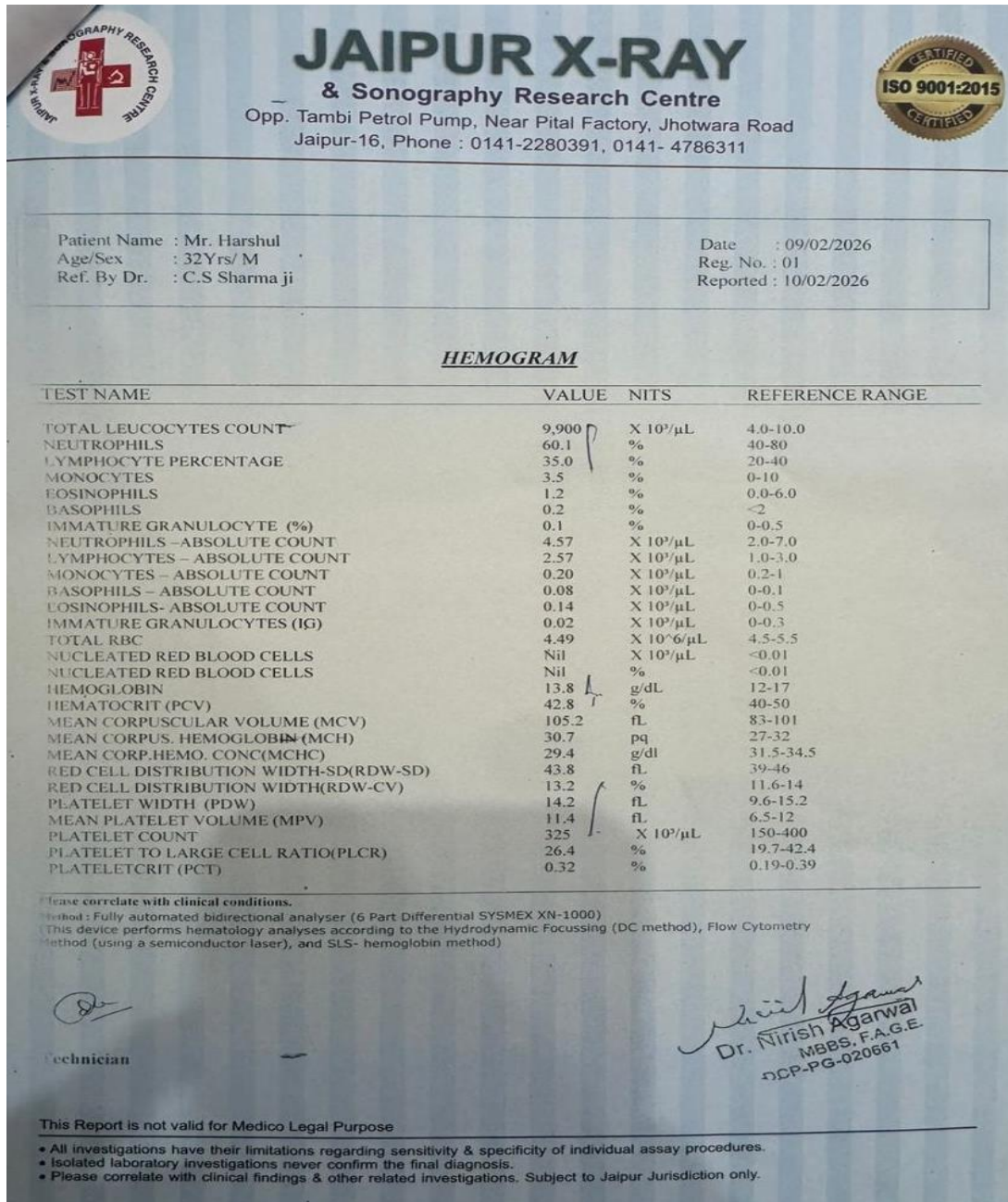




Figure 1: Baseline complete blood count (CBC) report (9 February 2026) showing total leukocyte count 9,900/ μ L with 60% neutrophils, normal haemoglobin and platelet counts, consistent with mild inflammation without leukocytosis.



JAIPUR X-RAY
& Sonography Research Centre
Opp. Tambi Petrol Pump, Near Pital Factory, Jhotwara Road
Jaipur-16, Phone : 0141-2280391, 0141- 4786311

Patient Name : Mr. Harshul
Age/Sex : 32Yrs/ M
Ref. By Dr. : C.S Sharma ji

Date : 09/02/2026
Reg. No. : 01
Reported : 10/02/2026

IMMUNOASSAY

TEST NAME	TECHNOLOGY	VALUE	UNITS	NORMAL RANGE
HIGH SENSITIVITY C-REACTIVE PROTEIN (HS-CRP)	IMMUNOTURBIDIMETRY	47.1	mg/L	Adult : <=3.0 mg/L

Interpretation:
High sensitivity C-reactive protein, when used in conjunction with other clinical laboratory evaluation of acute coronary syndromes, may be useful as an independent marker of prognosis for recurrent events, in patients with stable coronary disease or acute coronary syndromes. hsCRP levels should not be substituted for assessment of traditional cardiovascular risk factors. Patients with persistently unexplained, marked elevation of hsCRP after repeated testing should be evaluated for non - cardiovascular etiologies.

Clinical significance:
hsCRP measurements may be used as an independent risk marker for the identification of individuals at risk for future cardiovascular disease. Elevated CRP values may be indicative of prognosis of individuals with acute coronary syndromes, and may be useful in the management of such individuals.

Method:- FULLY AUTOMATED LATEX AGGLUTINATION – BECKMAN COULTER

Please correlate with clinical conditions.

Technician

Dr. Nirish Agarwal
Dr. Nirish Agarwal
MBBS, F.A.G.E.
DCP-PG-020661

This Report is not valid for Medical Purpose

- All investigations have their limitations regarding sensitivity & specificity of individual assay procedures.
- Isolated laboratory investigations never confirm the final diagnosis.
- Please correlate with clinical findings & other related investigations. Subject to Jaipur Jurisdiction only.

Figure 2: Baseline high-sensitivity C-reactive protein (CRP) report (9 February 2026) documenting elevated CRP at 47.1 mg/L, indicating marked systemic inflammation in acute appendicitis.

Abdominal ultrasonography on 9 February 2026 demonstrated a non-compressible, blind-ending tubular structure arising from the caecum in the right iliac fossa, measuring approximately 12–13 mm in outer diameter, with wall thickening,

probe tenderness and surrounding echogenic mesentery; no abscess, perforation or free fluid was seen. These findings, together with migratory pain, right iliac fossa tenderness and elevated CRP, supported a diagnosis of early uncomplicated acute appendicitis.

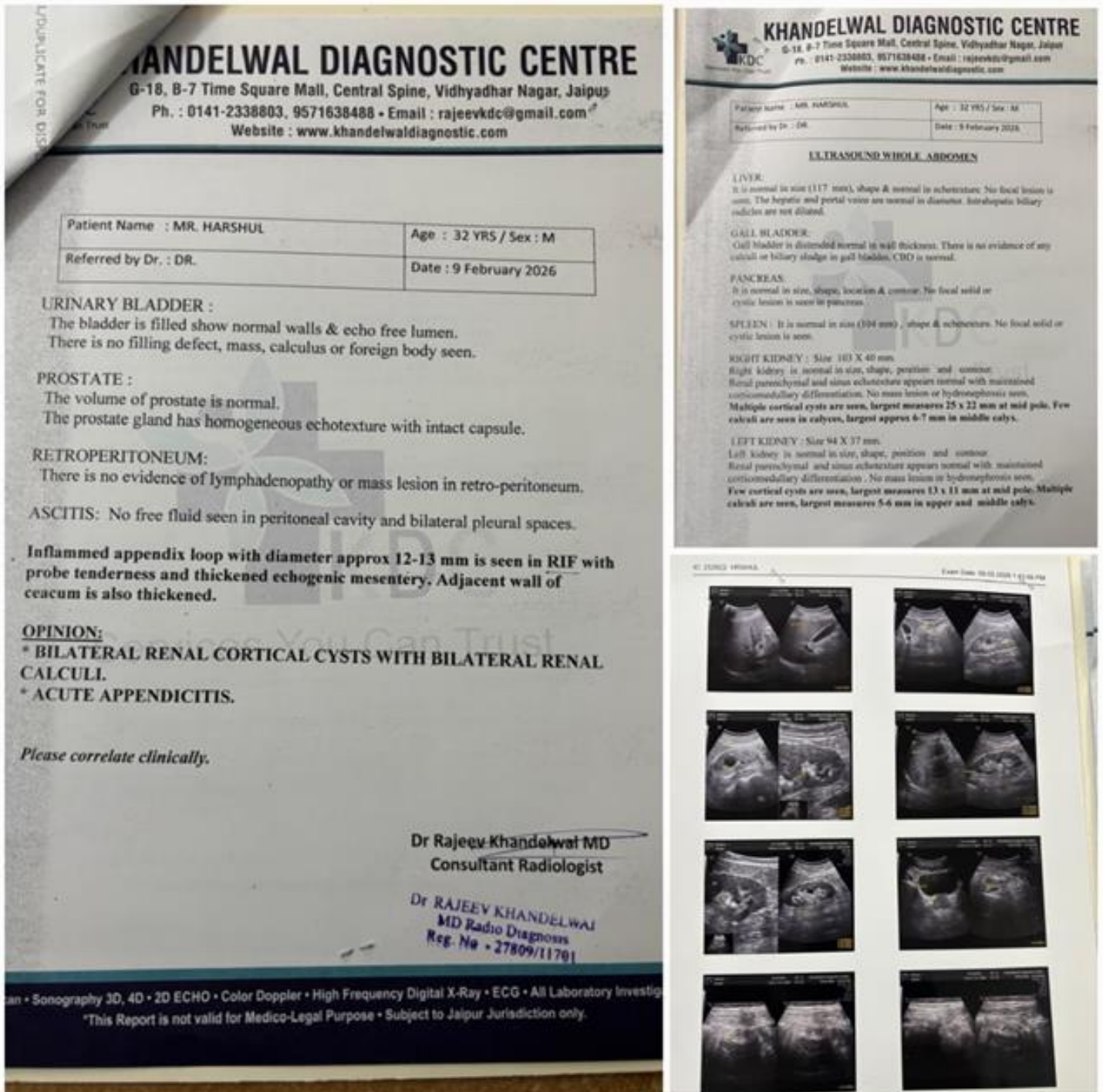


Figure 3: Baseline abdominal ultrasonography (9 February 2026) showing an inflamed appendix loop with diameter approx. 12-13 mm in RIF with probe tenderness, thickened echogenic mesentery, and caecal wall thickening, suggestive of acute appendicitis.

Alvarado Score

The Alvarado score, also known by the mnemonic MANTRELS, assigns points to eight clinical and laboratory items with a total possible score of 10.¹²

AIR Score

The Appendicitis Inflammatory Response (AIR) score combines symptoms, signs and inflammatory markers and has a total possible score of 12.¹³

Differential diagnoses included mesenteric adenitis, terminal ileitis, Meckel's diverticulitis, renal or ureteric colic and right-sided colonic diverticulitis, but the imaging pattern strongly favored appendicitis. Because there were no clinical or imaging signs of complicated disease, the presentation was considered low-risk uncomplicated appendicitis at baseline.^{3,5}

Therapeutic Intervention

Counselling and decision-making

The patient was counselled regarding standard surgical management of acute appendicitis, the role of appendectomy and the potential risks of non-operative management, including perforation, abscess formation, generalized peritonitis and sepsis. He reported the recent use of antibiotics prescribed elsewhere, which caused him gastric upset and also expressed fear of surgery. Therefore, he refused surgery and conventional medication but agreed to strict follow-up and urgent evaluation if red-flag symptoms occurred. Given the absence of systemic toxicity and the lack of complicated features on imaging, a shared decision was made to proceed with conservative Homoeopathic management under close observation. He was provided with written instructions and emergency contact details.

Homoeopathic management

An individualized Homoeopathic regimen was initiated on 9 February 2026. *Lycopodium clavatum* 1M was given as a single stat dose, selected on the basis of right-sided abdominal involvement, digestive susceptibility, flatulent distension and constipation, in line with its traditional materia medica indications. Within the first day after this dose, the patient reported slight easing of abdominal discomfort.

Because localized pain and inflammatory features persisted, *Belladonna* 200 and *Iris tenax* 30 were prescribed three times daily in alternation to address the acute inflammatory state and the ileo-caecal region more specifically, consistent with previously described homoeopathic usage in appendiceal complaints.^[14] Within about one week of this regimen, the patient reported marked relief in his pain and associated symptoms, and subsequent serial clinical, laboratory and ultrasonographic findings continued to improve.

Supportive measures

In addition to medicinal treatment, supportive advice included rest, adequate oral hydration, avoidance of self-prescribed analgesics or antibiotics, and a graded dietary plan. On 9 February 2026, the patient was advised to remain on a liquid diet. When he returned on 15 February with symptoms already better after 1–2 days of medication, he was advised to begin semi-solid meals. On 26 February, when he was clinically much better, he was advised to start solid meals in small portions.

Follow-up and outcomes

The patient was reviewed frequently during the initial weeks with clinical examination, safety-net advice and serial investigations. Clinical improvement was apparent within 24–48 hours, with marked reduction in pain by 15 February, minimal residual discomfort by 26 February and complete symptomatic recovery by the final follow-up in March.

Table 1: Timeline of clinical follow-up, homoeopathic interventions, dietary advice, and key investigation findings from presentation to resolution.

Date (2026)	Clinical status	Homoeopathic intervention	Dietary advice	Key investigation findings
9 Feb	Initial presentation with right iliac fossa pain, nausea, vomiting, low-grade fever, localized tenderness and guarding. Red-flag symptoms reviewed; written instructions provided.	Lycopodium clavatum 1M stat; Belladonna 200 TDS; Iris tenax 30 TDS in alternation	Liquid diet	USG: inflamed non-compressible appendix 12–13 mm with wall thickening and periappendiceal echogenic mesentery; CRP 47.1 mg/L
15 Feb	Pain markedly reduced; afebrile; moving comfortably. Safety-net counselling repeated; patient compliant.	Continued Belladonna 200/TDS and Iris tenax 30/ TDS in alternation	Semi-solid diet advised	USG: appendix reduced to about 8–9 mm with decreased inflammatory changes

Date (2026)	Clinical status	Homoeopathic intervention	Dietary advice	Key investigation findings
26 Feb	Only mild intermittent discomfort; bowel habits and appetite improving. Red-flag symptoms reviewed; no concerns reported.	Same medicines with tapering initiated or as and when required.	Solid meals in small portions	USG: appendix loop 6–7 mm with mild residual echogenic mesentery

24 Mar	Asymptomatic; normal appetite and bowel habits; no tenderness. Final safety-net counselling; emergency access confirmed.	Treatment stopped	Regular diet tolerated	USG: appendix about 5 mm; no probe tenderness or periappendiceal inflammation; CRP 0.83 mg/L
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Alvarado Score

Applied to this case, the baseline Alvarado score was 7/10, reflecting migration of pain, anorexia, nausea/vomiting, right iliac fossa tenderness, rebound tenderness and mild fever, while leukocytosis and left shift were absent.

Table 2: Serial Alvarado score assessment (baseline to final follow-up), showing decline from 7/10 to 0/10 paralleling symptom resolution.

Alvarado Component	Points (max)	9 Feb 2026	15 Feb 2026	26 Feb 2026	24 Mar 2026
Migration of pain	1	Present = 1	0	0	0
Anorexia	1	Present = 1	Improved = 0	Appetite returning = 0	Normal appetite = 0
Nausea/vomiting	1	Present = 1	Absent/ improved = 0	Absent = 0	Absent = 0
Right iliac fossa tenderness	2	Present = 2	Reduced clinically = 1	Minimal = 1	Absent = 0
Rebound pain	1	Present = 1	Not evident = 0	Absent = 0	Absent = 0
Elevated temperature	1	Present = 1	Afebrile = 0	Afebrile = 0	Afebrile = 0
Leukocytosis	2	0 (9,900/ μ L)	0 (6,200/ μ L on 13 Feb)	0 (6,600/ μ L on 21 Feb)	0 (normal)
Left shift	1	0 (60% neutrophils)	0	0	0
Total	10	7/10	1/10	1/10	0/10

AIR Score

Applied to this case, the baseline AIR score was 5/12, placing the patient in an intermediate-risk clinical category consistent with early uncomplicated appendicitis.

Table 3: Serial Appendicitis Inflammatory Response (AIR) score assessment (baseline to final follow-up), declining from 5/12 to 0/12 with treatment.

AIR Component	Points (max)	9 Feb 2026	13 Feb 2026	21 Feb 2026	24 Mar 2026
Vomiting	1	1	0	0	0
Right iliac fossa pain	1	1	1 (improving)	1 (residual earlier in course)	0
Rebound tenderness/ muscular Defence	3	2	0-1 (clinically improved)	0	0
Temperature ≥ 38.5 °C	1	0	0	0	0
PMN %	2	0 (60%)	0	0	0
WBC	2	0 ($9.9 \times 10^9/L$)	0 ($6.2 \times 10^9/L$)	0 ($6.6 \times 10^9/L$)	0
CRP	2	1 (47.1 mg/L)	0 (4.75 mg/L)	0 (3.9 mg/L)	0 (0.83 mg/L)
Total	12	5/12	1-2/12	1/12	0/12

Serial Laboratory Findings

Laboratory monitoring paralleled the clinical course. On 13 February 2026, total leukocyte count was 6,200/ μ L and CRP had fallen to 4.75 mg/L. On 21 February 2026, leukocyte count was 6,600/ μ L and CRP 3.9 mg/L. On 24 March 2026, the blood count was within reference ranges and CRP was 0.83 mg/L. Overall, CRP declined from 47.1 mg/L at baseline to within the reference range by six weeks, while leukocyte counts remained normal throughout follow-up, and ultrasonography showed parallel reduction in appendiceal diameter and inflammatory changes.

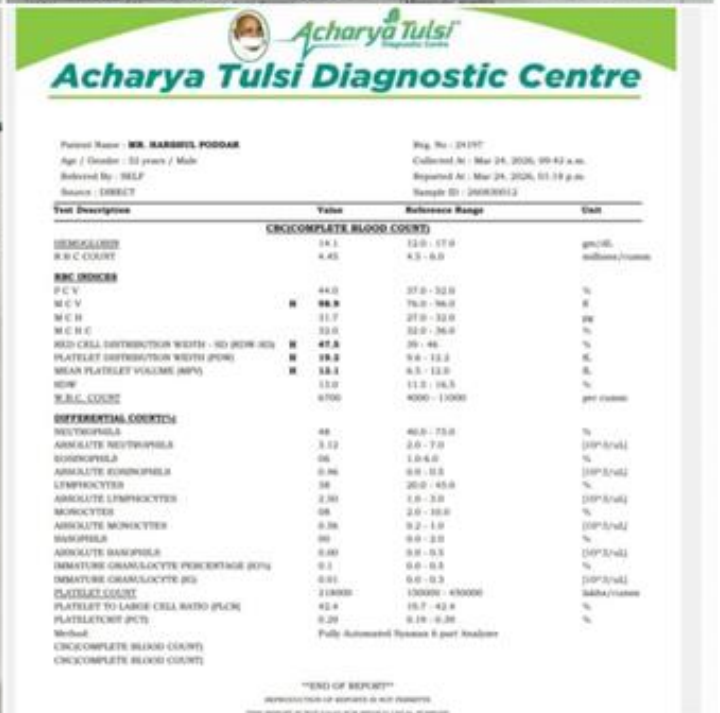


Figure 4: Serial complete blood count (CBC) reports (9 Feb, 13 Feb, 21 Feb, 24 Mar 2026) showing total leukocyte count trending from 9,900/ μ L to normal range.

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ISO 9001:2015

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Clinical significance:
hsCRP measurements may be used as an independent risk marker for the identification of individuals at risk for future cardiovascular disease. Elevated CRP values may be indicative of prognosis of individuals with acute coronary syndromes, and may be useful in the management of such individuals.

Method: FULLY AUTOMATED LATEX AGGUTINATION - BECKMAN COULTER
*Use sensitive with elevated conditions.

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Website : www.khandelwaldiagnostic.com

Referred By: Dr. C.S. SHARMA
Reg. no. 1607252098
Collected on: 13/02/2026

Age / Sex: 32 YRS / M
Date: 13/02/2026
LHD: UHID
Reported on: 13/02/2026 11:01 AM

SEROLOGY & IMMUNOLOGY

TEST	VALUE	UNIT	REFERENCE
C-Reactive Protein, CRP (Quantitative)	4.75	mg/L	< 6 mg/L

Interpretation:
- Produced in the liver and migrates in Y region, where it can produce a small pseudo paraprotein.
- A marker of systemic inflammation
- High Sensitivity CRP (hs CRP) assay may indicate cardiovascular risk
- Seasonal variations with highest levels in winter.

Note:
1. CRP is an acute phase reactant which is used in inflammatory disorders for monitoring course and effect of therapy.
2. It is most useful as an indicator of activity in Rheumatoid arthritis, Rheumatic fever, tissue injury or necrosis and infections.
3. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR.
4. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.

End of report

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Website : www.khandelwaldiagnostic.com

Referred By: Dr. C.S. SHARMA
Reg. no. 1607252098
Collected on: 21/02/2026

Age / Sex: 32 YRS / M
Date: 21/02/2026
LHD: UHID
Reported on: 21/02/2026 11:36 AM

SEROLOGY & IMMUNOLOGY

TEST	VALUE	UNIT	REFERENCE
C-Reactive Protein, CRP (Quantitative)	3.9	mg/L	< 6 mg/L

Interpretation:
- Produced in the liver and migrates in Y region, where it can produce a small pseudo paraprotein.
- A marker of systemic inflammation
- High Sensitivity CRP (hs CRP) assay may indicate cardiovascular risk
- Seasonal variations with highest levels in winter.

Note:
1. CRP is an acute phase reactant which is used in inflammatory disorders for monitoring course and effect of therapy.
2. It is most useful as an indicator of activity in Rheumatoid arthritis, Rheumatic fever, tissue injury or necrosis and infections.
3. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs, the intensity of the rise being higher than ESR and the recovery being earlier than ESR.
4. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, Polycythemia etc.

End of report

Acharya Tulsī Diagnostic Centre

Patient Name: MR. HARSHUL POGDAR
Age / Gender: 32 years / Male
Referred By: SELF
Specimen: DIRECT

Reg. No: 24197
Collected At: Mar 24, 2026, 09:42 a.m.
Reported At: Mar 24, 2026, 01:18 p.m.
Sample ID: 260630012

CRP QUANTITATIVE

Test Description	Value	Reference Range	Unit
C-Reactive Protein, Serum by Turbidity	0.83	0 - 3.0	mg/L

Remarks:
C-Reactive protein (CRP) which is synthesized in the liver, is one of the most sensitive acute phase reactants after tissue damage or inflammation. CRP activates the classical complement pathway as a response to the inflammatory reaction. CRP levels in plasma can rise dramatically after myocardial infarction, stroke, trauma, infection, inflammation, surgery or vascular prosthesis. The increase occurs within 24 to 48 hours & the level may be 2000 times normal. An elevation can be reported in virtually all diseases involving tissue damage as the findings are nonspecific. Clinical diagnosis should not be made on the findings of a single test result.

END OF REPORT

Asher Khan
LAB TECHNOLOGIST

Dr. Anurag Singh
M.D. Pathology
PATHOLOGIST
MNC NO: 61139

Figure 5: Serial high-sensitivity C-reactive protein (CRP) reports (9 Feb: 47.1 mg/L; 13 Feb: 4.75 mg/L; 21 Feb: 3.9 mg/L; 24 Mar: 0.83 mg/L) documenting normalization of inflammation.

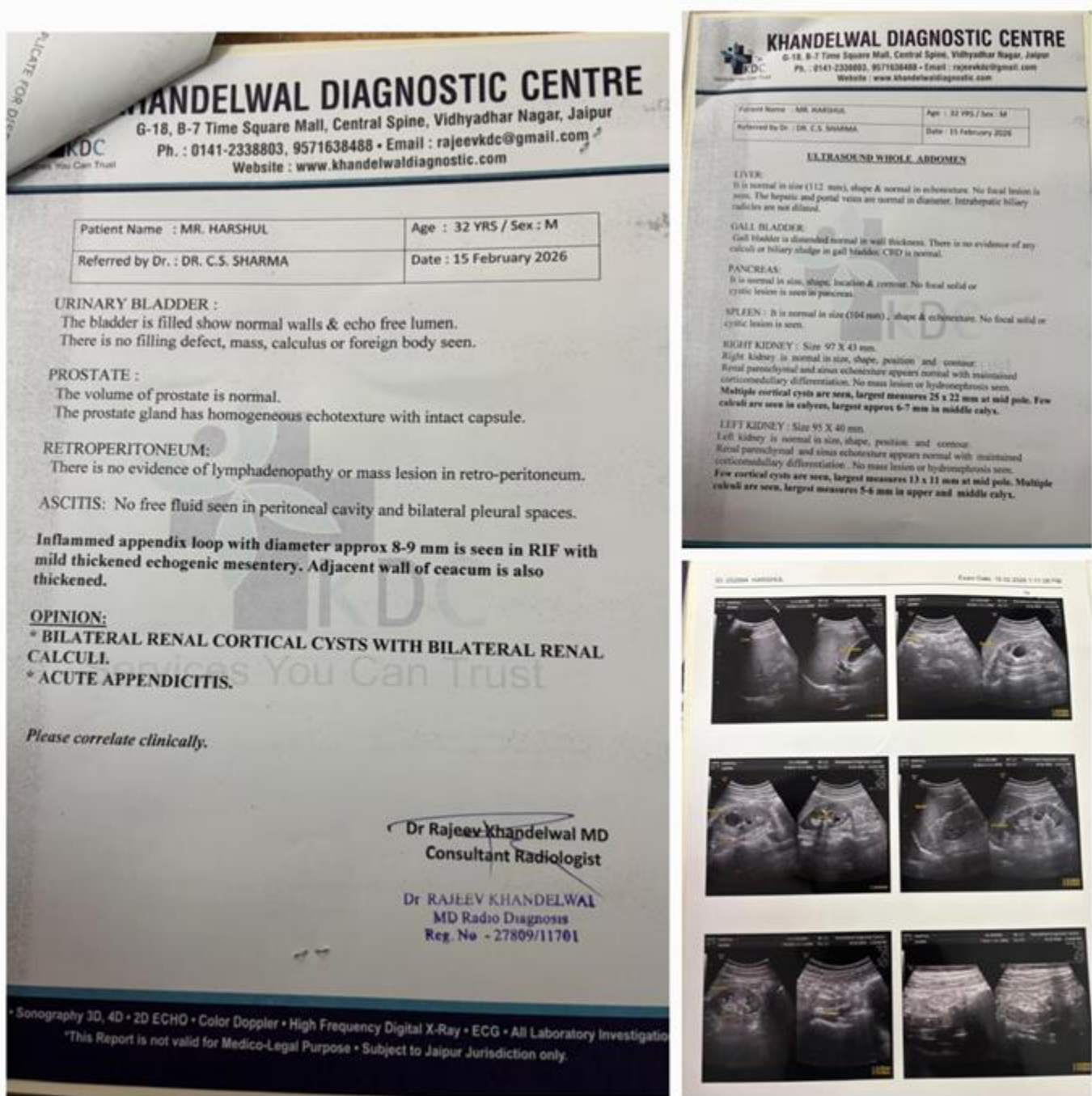


Figure 6: Follow-up abdominal ultrasonography (15 February 2026) showing reduced appendiceal diameter (8-9 mm) with decreased inflammatory changes.

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 Website : www.khandelwaldiagnostic.com

KDC
 Services You Can Trust

Patient Name : MR. HARSHUL	Age : 32 YRS / Sex : M
Referred by Dr. : DR. C.S. SHARMA	Date : 26 February 2026

URINARY BLADDER :
 The bladder is filled show normal walls & echo free lumen.
 There is no filling defect, mass, calculus or foreign body seen.

PROSTATE :
 The volume of prostate is normal.
 The prostate gland has homogeneous echotexture with intact capsule.

RETROPERITONEUM:
 There is no evidence of lymphadenopathy or mass lesion in retro-peritoneum.

ASCITIS: No free fluid seen in peritoneal cavity and bilateral pleural spaces.

Appendix loop is prominent with diameter approx 6-7 mm is seen in RIF with mild thickened echogenic mesentery.

OPINION:
 * BILATERAL RENAL CORTICAL CYSTS WITH BILATERAL RENAL CALCULI
 * PROMINENT APPENDIX LOOP WITH SURROUNDING INFLAMMATION.

Please correlate clinically.

Dr Mukesh Bijarniya MD
 Consultant Radiologist

Dr MUKESH BIJARNIYA
 MD Radio Diagnosis
 Reg. No.-3611829837

an • Sonography 3D, 4D • 2D ECHO • Color Doppler • High Frequency Digital X-Ray • ECG • All Laboratory Investig
 *This Report is not valid for Medico-Legal Purpose • Subject to Jaipur Jurisdiction only.

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 Ph. : 0141-2338803, 9571638488 • Email : rajeevkdc@gmail.com
 Website : www.khandelwaldiagnostic.com

Patient Name : MR. HARSHUL Age : 32 YRS / Sex : M
 Referred by Dr. : DR. C.S. SHARMA Date : 26 February 2026

ULTRASOUND WHOLE ABDOMEN

LIVER:
 It is normal in size (131 mm), shape & normal in echotexture. No focal lesion is seen. The hepatic and portal veins are normal in diameter. Intrahepatic biliary radicles are not dilated.

GALL-BLADDER:
 Gall bladder is distended normal in wall thickness. There is no evidence of any calculi or biliary sludge in gall bladder. CBD is normal.

PANCREAS:
 It is normal in size, shape, location & contour. No focal solid or cystic lesion is seen in pancreas.

SPLEEN : It is normal in size (104 mm) , shape & echotexture. No focal solid or cystic lesion is seen.

RIGHT KIDNEY : Size 99 X 48 mm.
 Right kidney is normal in size, shape, position and contour. Renal parenchymal and sinus echotexture appears normal with maintained corticomedullary differentiation. No mass lesion or hydronephrosis seen. Multiple cortical cysts are seen, largest measures 23 x 22 mm at mid pole. Few calculi are seen in calyces, largest approx 7 mm in middle calyx.

LEFT KIDNEY : Size 101 X 43 mm.
 Left kidney is normal in size, shape, position and contour. Renal parenchymal and sinus echotexture appears normal with maintained corticomedullary differentiation. No mass lesion or hydronephrosis seen. Few cortical cysts are seen, largest measures 18 x 12 mm at mid pole. Multiple calculi are seen, largest measures 5 mm in upper and middle calyx.



Figure 7: Further follow-up ultrasonography (26 February 2026) showing continued improvement (appendix 6-7 mm) with mild residual echogenic mesentery.

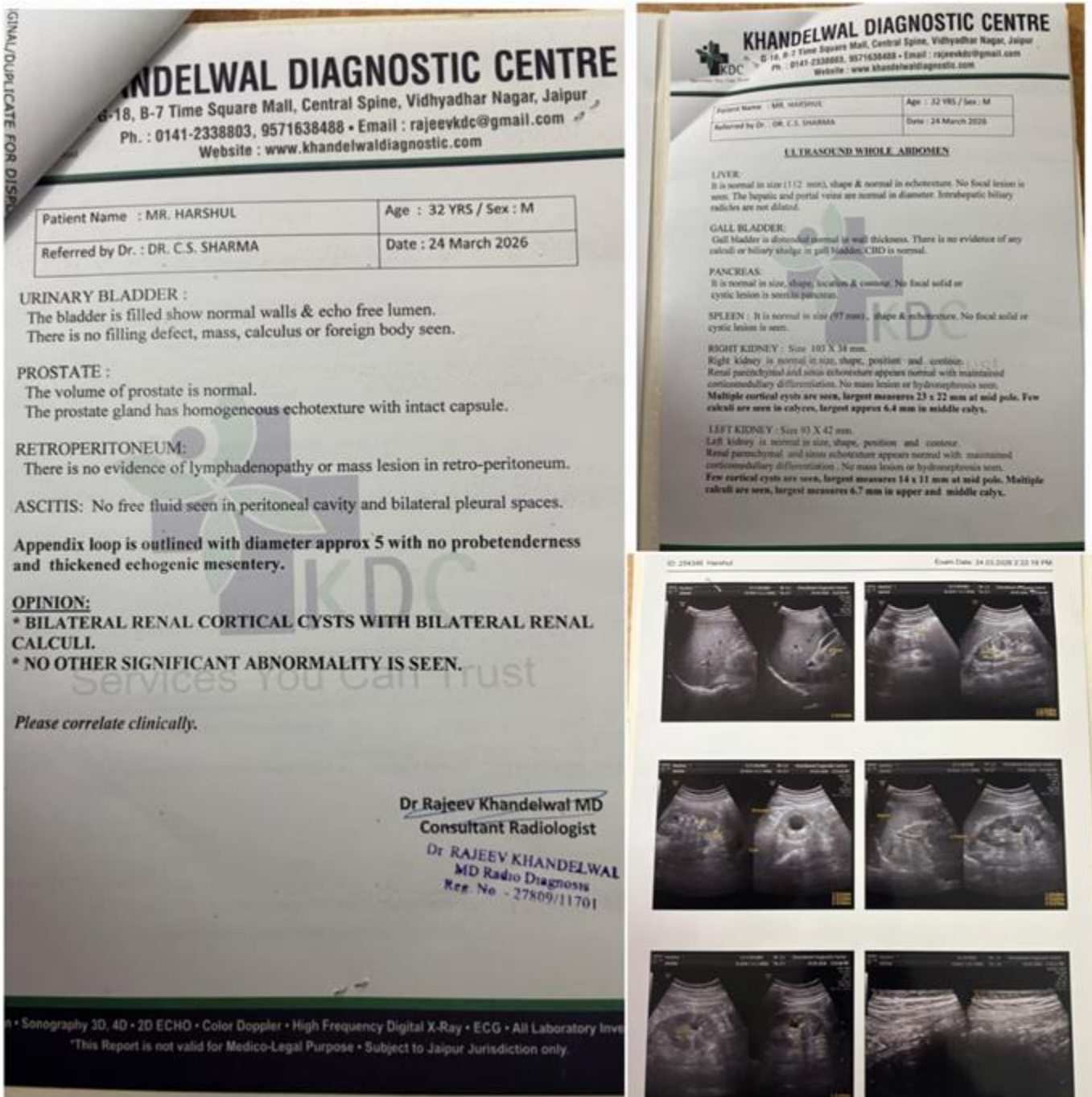


Figure 8: Final abdominal ultrasonography (24 March 2026) showing normal appendix (~5 mm diameter) with complete resolution of inflammation.

Clinical Outcome and Safety

Pain intensity decreased noticeably within 24–48 hours of treatment, and by the end of February the patient had resumed routine activities. At final follow-up in March he was free of abdominal pain, had normal bowel habits and appetite, and showed no tenderness on examination. No adverse drug reactions, suspected homoeopathic aggravations or unexpected events were documented. At each visit he was re-counselled about red-flag symptoms and agreed to attend emergency services immediately if they appeared.

Monarch Causal Attribution

The Modified Naranjo Criteria for Homeopathy (MONARCH) provide a structured method to assess the likelihood that an observed outcome is causally related to a homeopathic intervention. The inventory includes 10 domains addressing improvement, timing, aggravation, associated changes, overall well-being, direction of cure, old symptoms, alternative explanations, objective confirmation and repeat dosing response.

Table 4: Modified Naranjo Criteria for Homoeopathy (MONARCH) inventory applied to this case, yielding a total score of +5 compatible with possible causal attribution.

Domain	Monarch Question	Response in this case	Score
1	Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	Yes	+2
2	Did the clinical improvement occur within a plausible timeframe relative to the medicine intake?	Yes	+1
3	Was there a homeopathic aggravation of symptoms?	No	0
4	Did the effect encompass more than the main symptom or condition?	Yes	+1
5	Did overall well-being improve?	Yes	+1
6A	Did some symptoms improve in the opposite order of development?	Unclear	0
6B	Did improvement follow any aspect of direction of cure?	Unclear	0
7	Did old symptoms reappear temporarily during improvement?	No	0
8	Are there alternative causes that could have produced the improvement?	Yes	-3
9	Was the improvement confirmed by objective evidence?	Yes	+2
10	Did repeat dosing create similar clinical improvement?	Yes	+1
Total Monarch score			+5

The total MONARCH score of +5 (Range: -6 to +13) is compatible with a possible causal contribution of the homeopathic intervention while acknowledging plausible alternative explanations such as spontaneous resolution of uncomplicated appendicitis.⁹

Discussion

This case documents non-surgical resolution of imaging-confirmed early uncomplicated acute appendicitis in an adult who refused appendectomy and conventional medication but accepted close monitoring. The baseline presentation was consistent with acute appendicitis on clinical grounds, ultrasound findings and inflammatory marker elevation. The absence of perforation, abscess, diffuse peritonitis or sepsis supported classification as uncomplicated disease.⁵

A noteworthy feature of the case is the use of standardized appendicitis scores and structured causal attribution alongside the clinical narrative. The baseline Alvarado score of 7/10 and AIR score of 5/12 supported the initial diagnosis, while serial decline in these scores (0/10 and 0/12 respectively) documented parameters paralleled symptom resolution and objective improvement.^{12,13} Serial ultrasonography showed reduction of appendiceal diameter from 12–13 mm to about 5 mm, and CRP normalized over follow-up, strengthening the objective record of recovery.

Similar gradual reduction in appendiceal diameter under non-surgical management has been reported in an Ayurvedic case of paediatric appendicitis, where serial ultrasonography documented return to normal appendix size after herbal and dietary treatment.¹⁰ These observations suggest that, in some early uncomplicated cases, the inflammatory process may resolve under conservative or complementary care, though this is not yet well quantified. From a methodological perspective, this report demonstrates that Homoeopathic case reports can follow mainstream guidance (CARE) as well as Homoeopathy-specific extensions (HOM-CASE) and can incorporate structured causal assessment such as MONARCH, strengthening their potential contribution to the evidence base.^{6,7,8,9} At the same time, important limitations remain: this is a single case without control, spontaneous resolution cannot be ruled out, and imaging was limited to ultrasound.

Clinically, the key safety message is that appendicitis is still regarded as a surgical emergency. Non-operative approaches—whether antibiotic, Homoeopathic or Ayurvedic—should only be considered in highly selected patients, with full informed consent, easy access to surgery and rigorous follow-up. In this case, the conservative strategy was driven by the patient's informed refusal of surgery, not by an assumption that Homoeopathy is equivalent to appendectomy.

Patient Perspective

The patient reported that the pain and fear of surgery were initially intense but began to improve within two days of treatment. He expressed satisfaction that recovery occurred without surgery and appreciated frequent follow-up and clear warning-sign advice.

Informed Consent

Written informed consent was obtained from the patient for anonymised publication of the case details and investigation findings.

Conclusion

In a motivated, low-risk adult who declined surgery, acute appendicitis resolved under individualised Homoeopathic treatment, with improvement confirmed by serial ultrasonography, CRP measurements and Alvarado and AIR scores. The case has been reported in line with CARE and HOM-CASE guidelines and evaluated using the MONARCH inventory,

yielding a score compatible with a possible causal role of the Homoeopathic intervention. Larger prospective series and controlled studies are needed before such an approach can be recommended beyond exceptional circumstances.

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