

HOMOEOPATHIC MANAGEMENT OF RHEUMATOID ARTHRITIS WITH X-RAY: A CASE REPORT WITH SERIAL CLINICAL AND LABORATORY ASSESSMENT

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Abstract—Rheumatoid arthritis (RA) is a chronic systemic inflammatory disease characterized by persistent synovial inflammation, symmetrical polyarthritis, progressive joint destruction, and functional impairment. The present case report describes a 39-year-old female with a four-year history presenting pain and stiffness involving small joints of the hands, followed by involvement of knees and ankles, associated with generalized weakness and tingling sensations. X-ray was prescribed during different stages of treatment based on the homoeopathic assessment. This case illustrates the use of individualized homoeopathic prescribing in a patient with rheumatoid arthritis and highlights importance of the continual reassessment of the symptom picture during follow-up.

Index Terms—Rheumatoid arthritis, inflammatory polyarthritis, rheumatoid factor, C-reactive protein, X-ray, homoeopathy, joint pain, joint stiffness

I. Introduction

Rheumatoid arthritis (RA) is a chronic inflammatory disease characterized by a symmetric, erosive polyarthritis. It is one of the most common form of chronic inflammatory arthritis. Since persistently active RA results in articular cartilage and bone destruction and functional disability, it is vital to diagnose and treat this disease early and aggressively before damage ensues.¹

II. EPIDEMIOLOGY

Rheumatoid arthritis (RA) affects approximately **0.5–1%** of the adult population worldwide, although most epidemiological studies have been conducted in Western countries. The incidence and prevalence of RA vary according to geographic location and among different ethnic groups¹

III. GENETIC CONSIDERATIONS

Genetic factors play an important role in the occurrence and severity of rheumatoid arthritis (RA). The risk of developing RA is 2–10 times higher in first-degree relatives of affected individuals than in the general population. The estimated heritability of RA ranges from 40–60% and may be higher in patients

who are positive for anti-citrullinated protein antibodies (ACPA). The contribution of genetics varies among individuals due to interactions between genetic and environmental factors.¹

IV. PATHOLOGY

Rheumatoid arthritis primarily affects the synovial lining of diarthrodial joints and the underlying cartilage and bone. The normal synovial membrane is a thin connective tissue layer composed mainly of type A synoviocytes (macrophage-derived) and type B synoviocytes (fibroblast-derived). Synovial fibroblasts produce structural components of the joint, including collagen, fibronectin, laminin, and other extracellular matrix proteins.¹

The characteristic pathological features of RA are synovial inflammation, synovial hyperplasia, pannus formation, focal bone erosions, and progressive destruction of articular cartilage. Chronic inflammation causes proliferation of the synovial lining and formation of pannus, a thickened fibrovascular tissue that invades and destroys adjacent cartilage and bone. The inflammatory infiltrate consists predominantly of T lymphocytes, along with B lymphocytes, plasma cells, dendritic cells, mast cells, and granulocytes, all of which contribute to persistent inflammation and joint destruction.¹

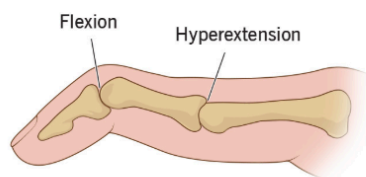
V. Clinical Features of Rheumatoid Arthritis (RA)

- The incidence of RA increases between 25 and 55 years of age, plateaus until 75 years, and then decreases.
- Presenting symptoms are typically related to inflammation of the joints, tendons, and bursae.
- Patients complain of early morning joint stiffness lasting more than 1 hour, which improves with physical activity.
- The earliest involved joints are usually small joints of the hands and feet.
- Initial joint involvement may be:
 - Monoarticular (one joint)
 - Oligoarticular (≤ 4 joints)
 - Polyarticular (>5 joints)
- Joint involvement is usually symmetrical.¹

Common deformities

- **Ulnar deviation** due to subluxation of the MCP joints with volar displacement of the proximal phalanx.
- **Swan-neck deformity:** Hyperextension of the PIP joint with flexion of the DIP joint.

Swan neck deformity



Cleveland Clinic. Swan neck deformity: what it is, causes & treatment Cleveland (OH): Cleveland Clinic; 2025 Feb 18 . Available from: [Cleveland Clinic webpage](#)

- **Boutonnière deformity:** Flexion of the PIP joint with hyperextension of the DIP joint.¹



Orthobullets. Boutonniere deformity [Internet]. Rosemont (IL): Orthobullets; Available from: [Orthobullets – Boutonniere Deformity](#)

- **Z-line deformity:** Subluxation of the first MCP joint with hyperextension of the first interphalangeal (IP) joint.

VI. CONSTITUTIONAL

- These signs and symptoms include weight loss, fever, fatigue, malaise, depression, and, in the most severe cases, cachexia; they generally reflect a high degree of inflammation and may even precede the onset of joint symptoms. In general, the presence of a fever of $>38.3^{\circ}\text{C}$ (101°F) at any time during the clinical course should raise suspicion of systemic vasculitis or infection.¹

EXTRA ARTICULAR MANIFESTATIONS

NODULES

- Subcutaneous nodules have been reported to occur in 30–40% of patients and more commonly in those with the highest levels of disease activity, who carry the disease-related shared epitope (SE), who have a positive test for serum rheumatoid factor (RF), and who show radiographic evidence of joint erosions. When palpated, the nodules are generally firm, nontender, and adherent to periosteum, tendons, or bursae; they develop in areas of the skeleton subject to repeated trauma or irritation such as the forearm, sacral prominences, and Achilles tendon.¹

- **HEMATOLOGIC**

A normochromic, normocytic anemia is the most common hematologic abnormality in patients with RA. The severity of anemia generally parallels the degree of inflammation and correlates with serum C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) levels. Platelet counts may also be elevated as part of the acute-phase response, whereas immune-mediated thrombocytopenia is rare.

CARDIAC

- The most frequent site of cardiac involvement in RA is the pericardium. However, clinical manifestations of pericarditis occur in $<10\%$ of patients with RA despite pericardial involvement being detectable in nearly one-half of cases by echocardiography or at autopsy. Up to 20% of patients with RA may have asymptomatic pericardial effusions on echocardiography.¹

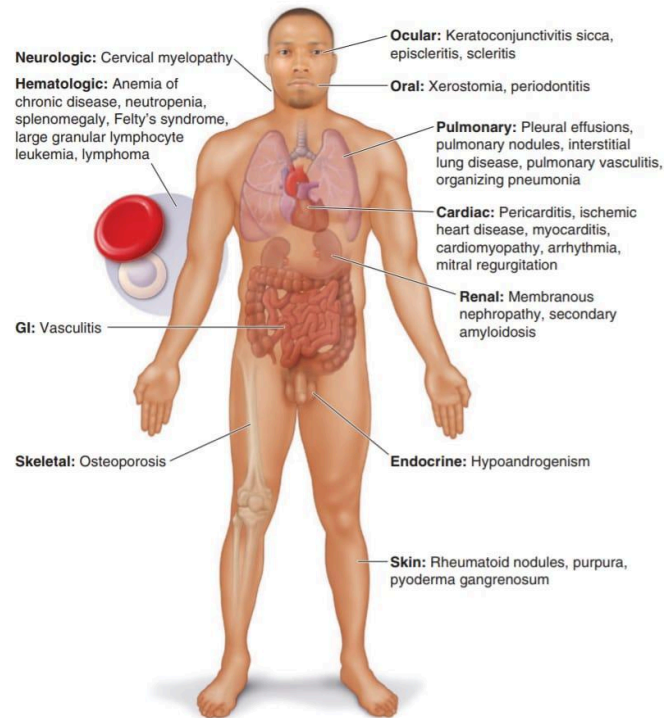


Figure 370-2 — “Extraarticular manifestations of rheumatoid arthritis”

VII. DIAGNOSIS

The diagnosis of rheumatoid arthritis (RA) is primarily based on the recognition of the clinical features of chronic inflammatory arthritis and the characteristic pattern of joint involvement, with laboratory and radiographic findings providing supportive evidence. In 2010, the American College of Rheumatology (ACR) and the European League Against Rheumatism (EULAR) introduced revised classification criteria to facilitate the early identification of patients who may benefit from prompt disease-modifying therapy. The criteria use a scoring system ranging from 0 to 10, and a score of ≥ 6 is considered consistent with definite RA.¹

TABLE 370-1 Classification Criteria for Rheumatoid Arthritis		
		SCORE
Joint involvement	1 large joint (shoulder, elbow, hip, knee, ankle)	0
	2–10 large joints	1
	1–3 small joints (MCP, PIP, thumb IP, MTP, wrists)	2
	4–10 small joints	3
	>10 joints (at least 1 small joint)	5
Serology	Negative RF and negative ACPA	0
	Low-positive RF or low-positive anti-CCP antibodies (≤ 3 times ULN)	2
	High-positive RF or high-positive anti-CCP antibodies (> 3 times ULN)	3
Acute-phase reactants	Normal CRP and normal ESR	0
	Abnormal CRP or abnormal ESR	1
Duration of symptoms	<6 weeks	0
	≥ 6 weeks	1

Table 370-1

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of rheumatoid arthritis (RA) includes various acute and chronic inflammatory arthritides, which can usually be differentiated based on the clinical course, pattern of joint involvement, extra-articular manifestations, and laboratory investigations.

Primary Sjögren's syndrome may resemble early RA because patients often present with polyarthralgia and mild inflammatory synovitis, and nearly 50% are positive for rheumatoid factor (RF). However, primary Sjögren's syndrome is characterized by dry eyes (keratoconjunctivitis sicca) and dry mouth (xerostomia) and is commonly associated with antinuclear antibodies (ANA) and anti-Ro/SSA antibodies.¹

INVESTIGATIONS

Erythrocyte Sedimentation Rate (ESR) and C-Reactive Protein (CRP)

Patients with rheumatoid arthritis (RA) commonly show elevated erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP), which are nonspecific markers of systemic inflammation and correlate with disease activity.

Rheumatoid Factor (RF)

Rheumatoid factor (RF) is an important serological marker used in the diagnosis of RA. The IgM isotype is the most commonly measured and is present in approximately 75% of patients with RA. However, RF lacks diagnostic specificity and may also be positive in other connective tissue diseases, chronic infections, and in 1–5% of healthy individuals. Therefore, a negative RF test does not exclude RA.

VIII. SYNOVIAL FLUID ANALYSIS

Synovial fluid in RA typically shows features of acute inflammatory arthritis, with a white blood cell count ranging from 5,000–50,000 cells/ μ L, predominantly neutrophils. Synovial fluid analysis is useful in confirming inflammatory arthritis and excluding septic arthritis and crystal-induced arthritis such as gout or pseudogout.

Plain Radiography (X-ray)

Plain radiography is the most commonly used imaging technique in RA. Early findings include periarticular osteopenia, followed by soft tissue swelling, symmetrical joint space narrowing, and juxta-articular or subchondral erosions, particularly involving the wrists, metacarpophalangeal (MCP), proximal interphalangeal (PIP), and metatarsophalangeal (MTP) joints. Advanced disease may show joint subluxation, deformity, and collapse.

Magnetic Resonance Imaging (MRI)

MRI is highly sensitive for detecting synovitis, joint effusions, bone marrow edema, and early erosions before they become visible on plain radiographs. Bone marrow edema is considered an early predictor of future joint erosion. Although MRI provides excellent soft tissue detail, its routine use is limited by cost and availability.

Ultrasonography (USG)

Musculoskeletal ultrasonography, particularly power Doppler ultrasound, is useful for detecting synovitis, increased vascularity, tenosynovitis, and bone erosions.¹

IX. CASE REPORT

Patient Information

Name: Mrs. P.M. (Identity concealed)

Age/Sex: 39 years/Female

Occupation: Housewife

Chief Complaints

1. Pain in the metacarpophalangeal and interphalangeal joints of the left hand, later involving the right hand, since 4 years. Agg: open air, when patient is in bed
2. Pain in both knee joints extending to the ankles with dragging sensation since 2 years.
3. Morning stiffness of small joints.
4. Generalized weakness.
5. Tingling sensation in hands and legs.

History of Present Illness

The patient presented with progressively increasing pain involving the small joints of both hands, initially affecting the left metacarpophalangeal and interphalangeal joints and later the right hand. The pain was associated with morning stiffness, swelling of small joints, generalized weakness, and tingling sensation.

She also complained of pain in both knee joints extending to both ankles with a dragging sensation, aggravated by cold weather and first movement.

She had taken allopathic treatment for nearly one year with no significant relief.

Past Treatment History

- Treated with allopathic medicines for one year without satisfactory improvement.

Family History

No significant family history.

Physical Generals

- Appetite – Moderate
- Thirst – 1.5 litres/day
- Sleep – Disturbed due to pain
- Stool – Normal
- Urine – Normal
- Thermal reaction – Chilly patient

Mental General

- Anxiety regarding her elder daughter.

Physical Examination

- Pulse – 103/min
- Blood Pressure – 110/70 mmHg
- Weight – 61 kg

Investigations (21-08-2025)

- CRP: 21.68 mg/L
- Rheumatoid Factor: 130 IU/mL

Date	Complaints	Prescription
21-08-2025	Pain in left metacarpophalangeal and interphalangeal joints since 4 years, later involving the right hand; morning stiffness with swelling of small joints; dragging type of pain associated with generalized weakness and tingling sensation. Agg: open air, when patient is in bed Pain in both knees, ankles, legs and metatarsals since 2 years with burning pain, aggravated by overexertion and around 1–3 AM.	X-Ray 200 – 6 doses, placebo 1 month
18-11-2025	Pain in metacarpophalangeal and interphalangeal joints reduced by approximately 50%. Pain in knees and metatarsals persisted. Tingling of hands and legs persisted. Agg: open air, when patient is in bed	X-Ray 200 – 6 doses. Placebo 1 month
15-12-2025	Pain in metacarpophalangeal and interphalangeal joints completely relieved. Pain in both knees extending to	Placebo 1 month

	ankles and toes persisted. Bilateral flank pain associated with stiffness. Tingling of hands and legs reduced. Sleep refreshed. Appetite moderate.	
20-01-2026	● Pain in knees extending to ankles with dragging sensation. Agg: open air, when patient is in bed ● Stiffness of knee joints. ● Cold aggravates the complaints. ● Pain in lumbar region. ● Pain in neck.	Pulsatilla 200 (prescribed based on totality). Placebo 15 days
24-03-2026	Knee pain persisted with dragging sensation... Generals good	X-Ray 200 – 6 doses. Placebo 1 month
14-04-2026	Knee pain persisted with pricking pain. Osler's nodes present.. Neck pain and shoulder pain improved. Straight leg raising test positive at 45°. Repeat investigations advised.	X-Ray 1M – 2 doses.

C REACTIVE PROTEIN

BEFORE 21/08/2025

Shreyaan-Ishaan Educational Society's
HAMSA HOMEOPATHY MEDICAL COLLEGE
 HOSPITAL, RESEARCH & DIAGNOSTIC CENTRE
 Ksheerasagar Vill., Mulugu Mandal, Siddipet Dt. Telangana
 Ph. Nos. 6300440493 / 6302578721 Email: hamsahomeopathy@gmail.com

NAME : [REDACTED] SEX : FEMALE
 REQ NO : [REDACTED] AGE : 39 YEARS
 REF BY : Dr.KAVYA DATE : 21/08/2025

BLOOD FOR C-REACTIVE PROTEINS

Semi quantitative assay for detection of CRP

PARAMETER	RESULT	REFERENCE RANGE
C-REACTIVE PROTEIN:	21.68 mg/L	NEGATIVE: Less than 6 mg/L POSITIVE : 6 mg/L and More

METHOD: Semi quantitative method

**** END OF REPORT****

* Suggested Clinical correlation, if necessary kindly do [REDACTED]

AFTER 14/4/2026

Shreyaan-Ishaan Educational Society's
HAMSA HOMEOPATHY MEDICAL COLLEGE
HOSPITAL, RESEARCH & DIAGNOSTIC CENTRE
 Ksheerasagar Vill., Mulugu Mandal, Siddipet Dt. Telangana
 Ph. Nos. 63004 40493 / 89777 36505 Email: hamsahomeopathy@gmail.com

NAME : [REDACTED] SEX : FEMALE
 REQ NO : [REDACTED] AGE : 39 YEARS
 REF BY : Dr.SRINIVAS BABU KATHI DATE : 14/04/2026

BLOOD FOR C – REACTIVE PROTEINS

Semi quantitative assay for detection of CRP

PARAMETER	RESULT	REFERENCE RANGE
C-REACTIVE PROTEIN:	9.80 mg/L	NEGATIVE: Less than 6 mg/L POSITIVE : >6 mg/L and More

METHOD: Semi quantitative method

**** END OF REPORT****

LAB IN CHARGE: [REDACTED]

* Suggested Clinical correlation, if necessary kindly discuss [REDACTED]

RHEUMATOID FACTOR BEFORE - 21/08/2025

manipal TRUtest FAST, ACCURATE, RELIABLE

MEDCIS LABORATORY TEST REPORT

Name : [REDACTED] HA
 Age/ Gender : 39 years / Female Ref. Doctor : HAMSA HOMEOPATHI
 Sample Type : SERUM Collected : Aug 21, 2025, 09:44 p.m.
 Sample ID : 245376054 Received : Aug 21, 2025, 10:30 p.m.
 Client Name : 1TSHYD852A Reported : Aug 22, 2025, 12:18 a.m.

CLINICAL BIOCHEMISTRY

TEST DESCRIPTION	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
Rheumatoid Factor (RA test) RA test (Nephelometry/Immunoturbidimetry)	> 130.0	IU/mL	< 14.0

Interpretation:

- Rheumatoid factors are a heterogeneous group of autoantibodies directed against the antigenic determinants of the Fc γ -region of IgG molecules. They are important in the diagnosis of rheumatoid arthritis, but can also be found in other inflammatory rheumatic diseases and in various non-rheumatic diseases.
- RF is not specific only for Rheumatoid arthritis, but it is often seen in cases of chronic infection and other systemic inflammatory conditions. Healthy individuals > 65 years of age may also show positive RF results.

AFTER 14/4/2026

manipal TRUtest
FAST ACCURATE RELIABLE

MEDCIS
LABORATORY TEST REPORT

Name: [REDACTED] THA
Age/ Gender : 39 years / Female
Sample Type : SERUM
Sample ID : 248868361
Client Name : 1TSHYD852A

Ref. Doctor : HANSA HOMOEOPATHI
Collected : Apr 14, 2026, 10:31 p.m.
Received : Apr 14, 2026, 11:11 p.m.
Reported : Apr 15, 2026, 02:34 a.m.

CLINICAL BIOCHEMISTRY

TEST DESCRIPTION	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
Rheumatoid Factor (RA test)			
RA test (Immunoglobulin G)	122	IU/mL	<14.0

Interpretation:

- Rheumatoid factors are a heterogeneous group of autoantibodies directed against the antigenic determinants on the Fc-region of IgG molecules. They are important in the diagnosis of rheumatoid arthritis, but can also be found in other inflammatory rheumatic diseases and in various non-rheumatic diseases.
- RF is not specific only for Rheumatoid arthritis, but it is often seen in cases of chronic infection and other systemic inflammatory conditions. Healthy individuals > 65 years of age may also show positive RF results.

X. SOURCES OF HOMOEOPATHIC REMEDIES

“Homoeopathy presses into its service a far greater number of natural products than traditional medicine employs. It has revived many valuable agents from the unmerited oblivion into which they had fallen and is continually adding new remedies to its stock by means of the Organon it possesses in the law of similars.” — Richard Hughes

Various sources of homoeopathic drugs are:

- Plant kingdom.
- Animal kingdom.
- Mineral kingdom.
- Nosodes.
- Sarcodes.
- Imponderabilia.
- Synthetic source.

XI. DEFINITION OF IMPONDERABILIA

It means which is not weighable, i.e. the substance which has no perceptible weight. This is immaterial power or energy. Medicines prepared from energy available from natural and physical reactions are called ‘imponderabilia’.²

Source	Example	Homoeopathic Name
Natural Source	Normal magnet	<i>Magnetis poli ambo</i>
	North pole of magnet	<i>Magnetis polus arcticus</i>
	South pole of magnet	<i>Magnetis polus australis</i>
Artificial Source	Electricity	<i>Electricitas</i>
	Sun's rays	<i>Sol</i>

	Radium bromide	<i>Radium</i>
	Artificial magnet	<i>Magnetis artificialis</i>
	X-rays	<i>X-ray</i>

Collection of X-RAY

Specific instructions and rules for collecting and preparing these medicines are provided in the **Homoeopathic Pharmacopoeia**.

- For the preparation of **X-ray**, a chemical or radiological testing laboratory may be contacted.
- **Potentization of these medicines must be carried out with great care**, as they are prepared from imponderable sources of energy rather than material substances.²

Preparation of X-RAY

X-RAY An imponderabilia, prepared by exposing a phial containing alcohol to X-ray for half an hour. Dilutions are prepared according to the centesimal scale^{2,3}

Understanding the Drug picture of X-ray

Repeated exposure to Roentgen (*X-ray*) has produced skin lesions often followed by cancer. Distressing pain. Sexual glands are particularly affected. Atrophy of ovaries and testicles. Sterility. Changes take place in the blood lymphatics and bone marrow. Anæmia and leukæmia. Corresponds to stubbornness as in burns, they refuse to heal. Psoriasis.

Has the property of stimulating cellular metabolism. Arouses the reactive vitality, mentally and physically. Brings to the surface suppressed symptoms, especially sycotic and those due to mixed infections. Its homeopathic action is thus centrifugal, towards the periphery.

Head.--Sticking pains in different parts of head and face. Dull pain in right upper jaw. Stiff neck. Sudden cricks in neck, pains more severe behind ears. Pain in muscles of neck when lifting head from pillow. Fullness in ears, ringing in head.

Mouth.--Tongue dry, rough, sore. Throat painful on swallowing. Nausea.

Male.--Lewd dreams. Sexual desire lost. Re-establishes suppressed gonorrhœa.

Extremities.--Rheumatic pains. General tired and sick feeling. Palms rough and scaly.

Skin.--Dry, itching eczema. Erythema around roots of nails. Skin dry, wrinkled. Painful cracks. Warty growths. Nails thicken. Psoriasis.

Modalities.--*Worse*, in bed, afternoon, evening and night; open air.^{4,5}

Indications of locomotor system

Extremities.--Rheumatic pains. General tired and sick feeling. Palms rough and scaly.

Modalities.--*Worse*, in bed, afternoon, evening and night; open air.

- Such conditions previously treated with **X-Ray** or steroids may not respond to indicated medicines like **Causticum, Silicea, Calc-Fluor, Tuberculinum**, etc.
- In such cases, a dose of **X-Ray** may bring back the original symptoms, facilitating the selection of the correctly indicated drug. Thereby, it helps in making a correct second prescription.⁵

Single rubrics on X-RAY

- EXTREMITIES – CONGESTION – hands – fingers – X-ray
- EXTREMITIES – REDNESS – nails – roots – about – X-ray
- EXTREMITIES – REDNESS – fingers – fingernails – roots – around – X-ray
- EXTREMITIES – SMOOTHNESS – hands – palms – X-ray
- EXTREMITIES – ULCERS – painful – hands – back – with general weakness – X-ray⁶

XII. DISCUSSION

Rheumatoid arthritis is a chronic inflammatory disorder characterized predominantly by symmetrical involvement of the peripheral joints, particularly the small joints of the hands and feet. Persistent synovial inflammation may result in cartilage destruction, bone erosion, joint deformity, and functional disability. In the present case, the patient exhibited progressive involvement of the metacarpophalangeal and interphalangeal joints of the hands, followed by involvement of the knees and ankles, along with morning stiffness, swelling, generalized weakness, and tingling sensations. The clinical presentation was supported by laboratory findings, with elevated C-reactive protein and rheumatoid factor levels.

The case demonstrated the use of X-ray at different stages of management. The homoeopathic literature describes X-ray as an imponderable remedy and reports rheumatic pains and general tiredness among its indications, with aggravation in bed and in the open air. In the present case, its prescription was based on the homoeopathic assessment and the characteristic symptom picture rather than solely on the clinical diagnosis of rheumatoid arthritis.

The observed improvement in hand-joint symptoms and general well-being during follow-up represents a favourable clinical observation. However, as this is a single case report without a control group, the improvement cannot be attributed conclusively to homoeopathic treatment. Rheumatoid arthritis is a chronic disease with a variable clinical course, and objective assessment through serial inflammatory markers and appropriate imaging is important when evaluating disease activity and structural progression. Further systematic studies are required to determine the therapeutic role of individualized homoeopathic treatment in rheumatoid arthritis.

XIII. CONCLUSION

This case describes a patient with rheumatoid arthritis presenting with progressive symmetrical joint involvement, morning stiffness, weakness, and associated neurological symptoms. Following individualized homoeopathic treatment, improvement was observed in the pain and stiffness of the small joints of the hands, tingling sensations, sleep, and general well-being, although knee pain persisted during later follow-up. The case highlights the importance of individualization and reassessment of the changing symptom picture during homoeopathic management.

XIV. CONSENT

Informed consent was obtained from the patient for publication of the case report and accompanying clinical information.

XV. Acknowledgement

The authors acknowledge Director Dr. Umesh Akkaladevi, Hamsa Homeopathy medical college, Hospital and Research centre for his valuable support and encouragement.

XVI. CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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