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EFFICACY OF GALPHIMIA GLAUCA COMPARED TO INDIVIDUALISED HOMOEOPATHY IN THE MANAGEMENT OF PERENNIAL ALLERGIC RHINITIS: A SYSTEMATIC REVIEW OF LITERATURE

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ABSTRACT

Background: Persistent Allergic Rhinitis is referred to as Perennial Allergic Rhinitis. Homeopathic treatments such as Galphimia Glauca as well as Individualized treatments have been studied, but many comparative studies reflect seasonal rather than perennial disease. Therefore, this review investigates the body of evidence that examines Perennial Allergic Rhinitis.
METHODS: A targeted search and appraisal informed by the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) statement, identified 11 distinct candidate clinical studies. Individual studies were assessed in a structured synthesis and five studies were included. Phenotype, Intervention, and Control groups, risk of Bias, and Explicit outcomes were recorded. Adjusted comparisons from a three-arm study were visualized without calculating an unsupported pooled effect. RESULTS: No Randomized Controlled Trials (RCTs) retrieved directly compared Galphimia Glauca and Individualized Homoeopathy for Perennial Allergic Rhinitis.
CONCLUSION: Evidence for the comparative effectiveness of treatments for Perennial Allergic Rhinitis is currently lacking.

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1. Introduction:-

Allergic Rhinitis is defined by the presence of nasal symptoms, including Rhinorrhea, Sneezing, Nasal Itching, and Nasal Obstruction caused by IgE-mediated inflammatory response. Symptoms occur as a result of ongoing exposure to various allergens, such as dust mites and dander, and are worsened by change in the season and presence of mold. Current classification of allergic rhinitis concentrates on the duration of symptoms, which are either intermittent or persistent. Symptoms of Allergic Rhinitis impact patient's daily functioning, including his/her ability to concentrate and sleep. In the absence of adequate control of allergic rhinitis symptoms, Intranasal Corticosteroids are considered first line of treatment, while Antihistamines and Allergen Immunotherapy are used as second line of treatment, based on the clinical need [1].

Galphimia Glauca is a botanical agent used in Homeopathy at a standardized potency. It should not be compared to a standardized herbal extract. Homeopathic medicines are individualized based on patient's symptoms and afflictions. Claims of efficacy of Galphimia should be distinguished from the effects of the consultation, expectation, and treatment, as well as from the changes in symptoms that occur spontaneously. The effectiveness of homeopathy in the treatment of Seasonal Allergic Rhinitis has been studied, and the methodological heterogeneity of those studies has been well documented.

The main problem in transportability of the evidence concerns the type of pollinosis: studies published to date focus on seasonal pollinosis and the evidence published in this review focuses on perennial pollinosis. Only a 2026 three-arm study provides treatment comparisons for seasonal pollinosis. A 2025 study, however, provided evidence for treatment of Perennial and Mixed Allergic Rhinitis with Individualized Homeopathy, including Galphimia [4]. This review aims to discriminate evidence for Perennial Allergic Rhinitis and appraise the certainty of the evidence.

2. Materials and Methods:-

2.1. Design and Eligibility

A PRISMA-compliant, structured review is reported, incorporating individually identifiable research reports and the PRISMA 2020 reporting guideline [5]. Prioritization of eligibility was given to clinical studies on Galphimia Glauca or Individualized Homoeopathy in the case of Allergic Rhinitis that identified participants, intervention/comparison/or a longitudinal outcome, and were report-based. The target population was Perennial Rhinitis; Seasonal and unclassified Rhinitis were classified as indirect evidence and were reported separately. Only RCTs and Observational Cohorts were considered. Secondary reviews, case series and other reports without interpretable clinical outcomes were considered ineligible and not included in the primary evidence table.

2.2. Source Identification and Extraction

Bibliographic searching was conducted until 10 October 2026 in PubMed and Scholarly web sources to locate institutional and/or publisher records. Relevant search terms included "Galphimia Glauca" and "Allergic Rhinitis"; "Individualized Homeopathy" and "Perennial Allergic Rhinitis"; "Rhinitis" and "Homeopathy" and "Randomized." The original journal article was retrieved through the cited record and/or PubMed and/or the institution where available, and documented case reports were included in the study. A total of 11 case reports were documented in the study. Due to the targeted nature of the search, the case reports were limited to the documented records. Therefore, the case reports may have been exported from MEDLINE, CENTRAL, Google Scholar, or Clinical Trials Registers. The case report selection counts only reflect the documented case reports.

For each report, the following data were extracted: Year, Rhinitis Phenotype, Study Design, Sample Size, Intervention, Comparator, Follow-Up, Patient-Reported Outcomes, And Safety and Statistical Outcomes. Where the original publications reported adjusted mean differences and 95% confidence intervals, these were extracted and reported as such. Imputation of missing Standard Deviations, Allocation Denominators, or Endpoint Observations was not done. Abstract-only publications were not used to calculate new effect sizes.

2.3. Documented Screening Audit

The Wiesenauer and Lüdtke, Taylor and colleagues, Dixit and colleagues, Patil and Patil, and Siewert and colleague reports have been included in this analysis. Other reports appraised at the identification or eligibility stage include the Banerjee systematic review and a Siewert qualitative feasibility report (secondary/non-efficacy sources); the Hiwase case series had no independent comparator; the Teixeira dissertation abstract report did not provide arm-level outcome detail required for this synthesis; and two other reports, labeled as trials, did not provide sufficiently verifiable endpoint by arm results for quantitative extraction. Including candidate records for this analysis does not imply that these reports were included in the efficacy synthesis.

2.4. Appraisal and Quantitative Synthesis

Quantitative appraisal was performed by assessing the risk of bias for Randomized studies against RoB 2 for randomization, deviations from assigned intervention, missing outcomes, measurement of outcome and selective reporting [6]. For observational before-after studies, we evaluated for confounding, regression to the mean, and the absence of a comparator. Evidence was downgraded for indirectness, imprecision and suspected bias. A formal meta-analysis was not applicable in this case since no set of

independent trials compared the same population with similar outcomes for Perennial Rhinitis. A Forest plot is included to show the comparison of three related treatments from the same trial. They should not be viewed as three independent treatments.

3. Results:-

3.1. Study Selection

There were 11 candidate reports. Two (A Secondary Review and A Qualitative Feasibility Study) were excluded during screening. Nine were viewed for eligibility. The case series, a dissertation abstract, and two reports which were deemed not to have sufficiently extractable results, were excluded, leaving five, which were viewed for structured synthesis. The count for quantitative pooling was zero. Documented counts are based on targeted selections and are not to be interpreted as a statement that 11 records exist in the literature.

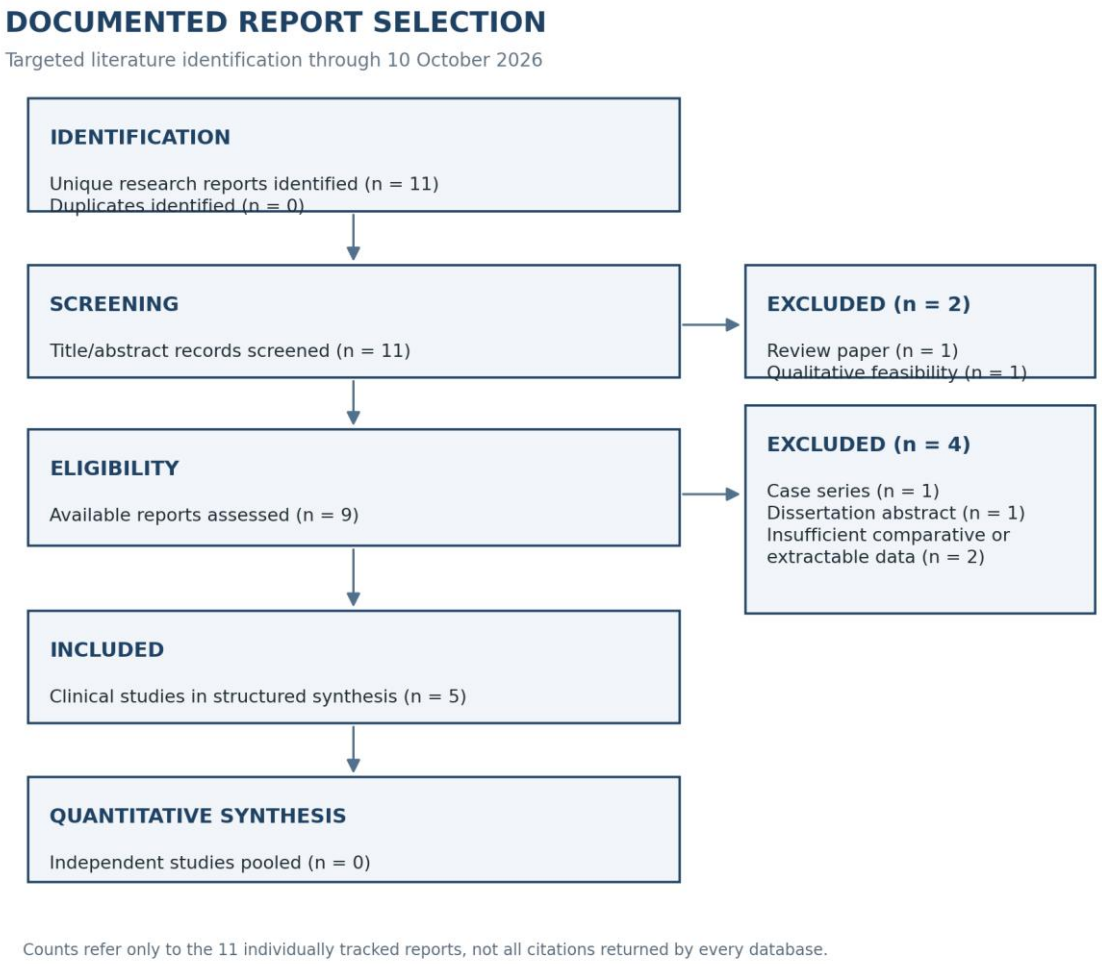


Figure 1. PRISMA-style flow of the 11 individually identified clinical/research reports; no comprehensive database-search denominator is claimed.

3.2. Characteristics of evidence

Study / Source	Phenotype; Design	N	Intervention / Comparator	Key Result
Wiesenauer&Lüdtke, 1995 [7]	Seasonal; blinded RCT	164	Galphimia D4 / placebo	Some nasal and ocular benefits at 2 weeks; nasal endpoint not confirmed at 4 weeks.
Taylor et al., 2000 [8]	Perennial; blinded RCT	51	Allergen-derived isopathic 30C / placebo	Nasal peak-flow difference 19.8 L/min (95% CI 10.4–29.1); not individualised prescribing.
Dixit et al., 2025 [4]	AR, subtype unstated; open-label RCT	210	Individualised + fluticasone / fluticasone	No additional TNSS improvement during treatment; week-18 differences reported.

Patil & Patil, 2025 [9]	AR, subtype unstated; single-arm	150	Individualised therapy / no control	TNSS 11.2 to 3.8 at 6 months; causal effect indeterminable.
Siewert et al., 2026 [3]	Seasonal; blinded 3-arm RCT	62	Galphimia D6 / individualised D6 / placebo	No significant between-group RQLQ or TNSS effects.

Table 1. Five included clinical studies. AR = allergic rhinitis; RCT = randomised controlled trial; TNSS = Total Nasal Symptom Score.

3.3. Comparative Outcomes and Safety

The HOMEOSAR Trial Randomised 62 Seasonal-Rhinitis Participants (Galphimia 23; Individualized 19; Placebo 20); the primary analysis involved 56 with complete endpoint data (22, 18 and 16, respectively). The adjusted mean RQLQ for weeks 3–4 was 1.2 (95% CI 0.7–1.7) with Galphimia, 1.7 (1.2–2.3) with Individualized treatment and 1.4 (0.8–2.0) with Placebo. Overall group difference was not significant (p=0.244). Responder rates were 86.4%, 66.7% and 81.3%; eight mild adverse events and no serious adverse events were reported [3].

Outcome / Comparison	Estimate (95% CI)	p value
RQLQ: Galphimia vs individualised [3]	−0.6 (−1.4 to 0.3)	0.232
RQLQ: Galphimia vs placebo [3]	−0.2 (−1.0 to 0.7)	0.844
RQLQ: individualised vs placebo [3]	0.4 (−0.5 to 1.2)	0.581
Week-12 TNSS, adjunctive vs standard [4]	No significant between-group benefit	>0.99
Week-18 TNSS, adjunctive vs standard [4]	1.44±1.00 vs 6.48±1.71	<0.001
Nasal peak flow, isopathy vs placebo [8]	19.8 L/min (10.4 to 29.1)	0.0001

Table 2. Published outcomes. Different comparators, disease phenotypes and time points preclude pooled interpretation.

The 2025 open-label study Randomized 210 patients to fluticasone alone or fluticasone plus individualized treatment. The authors found no additional TNSS improvement at weeks 4 or 12 but reported a large difference six weeks after treatment cessation (week 18: 1.44±1.00 versus 6.48±1.71; p<0.001). Because the comparison was not blinded and the source does not establish a Perennial-only cohort, this result cannot demonstrate Galphimia–Individualized superiority in perennial disease [4].

The Uncontrolled 2025 Cohort reported TNSS reduction from 11.2±2.8 to 3.8±3.1 among 150 treated patients, with no concurrent comparator [9]. The historical Perennial-Rhinitis RCT reported improved objective nasal airflow after allergen-derived isopathy, an intervention conceptually different from Individualized remedy selection [8]. Earlier Galphimia evidence derives from seasonal pollinosis [7].

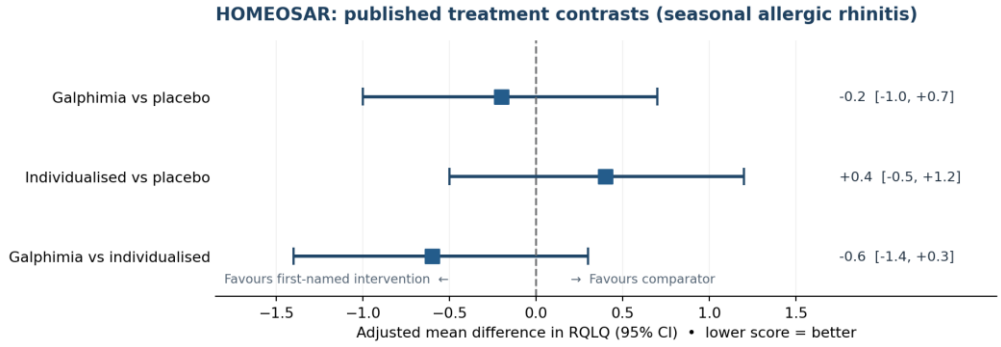


Figure 2. Forest-style display of adjusted RQLQ contrasts from one seasonal-rhinitis RCT [3]. All three confidence intervals cross zero. These are correlated contrasts, not an independent-trial meta-analysis; pooled weights and I^2 are inapplicable.

3.4. Study Quality and Interpretive Weight

The seasonal HOMEOSAR experiment features masked, Randomized assignment and a shared consultation process, but there is a significant shortfall in recruitment and six missing primary end point observations, reducing its precision [3]. The adjunctive study was Randomized but Open-label. Its departure at week 18 warrants independent confirmation, as the presence of measurement and performance biases in self-reported symptoms and unmasked follow-up limited the reliance that can be placed on it [4]. The 1995 Galphimia study utilized blinding, but has limited contemporary reporting on the methods used for sequence generation and

selective reporting [7]. The 2000 perennial study also limits its applicability to Individually prescribed preparations due to the use of allergen-derived interventions [8]. The prospective cohort has no control arm and is of limited value to determine comparative effects, due to high to moderate risk of bias, and high levels of indirectness and wide confidence intervals [9]. Therefore, we have very low confidence in the target comparative effect.

An earlier systematic review had identified 11 studies of Allergic Rhinitis, of which 8 were classified as high risk of bias. It's pooled Galphimia analysis was based on 3 studies and 2 weeks' data, and showed nasal improvement for Galphimia versus Placebo (risk ratio 1.48; 95% confidence interval, 1.24-1.77). For data at 4 weeks, risk ratio was 1.27 (95% CI, 1.10-1.46). These results date back a decade and focus on Galphimia vs Placebo rather than Individualized care. Results are not generalizable to continuous exposure to indoor allergens. Nasal improvement reported in the 1995 trial was not consistent [7].

A key conceptual problem is that Homeopathy is not a singular treatment, and thus asking different causal questions, as in individualized prescribing, isopathy, Galphimia, and adjunctive prescribing. Taylor and colleagues studied the homeopathic potency of a principal inhalant allergen, but not the remedy that was individually selected by consultation [8]. The 2025 adjunctive RCT, which tested Galphimia versus an Intranasal Corticosteroid, showed no improvement during the treatment phase [4]. Allergic Rhinitis has many causative factors and symptoms are influenced by many factors including exposure to allergens, medication, and regression to the mean [9].

Risk of bias also modifies how we interpret seemingly favorable p-values. Open-label assessment can result in expectation effects, and analyses after treatment discontinuation raise concerns about differential rescue medication and follow-up. In the 2026 masked trial, all arms underwent the same Individualized case-taking process, thus contributing to isolating the effect of the assigned remedy; the absence of meaningful between-arm differences argues against a short-term specific medicine effect for that seasonal population [3]. For clinical practice, other validated Intranasal Therapies are supported by stronger evidence [1]. A 2025 systematic review of phytotherapy addresses plant-based products, but should not be confused with ultra-diluted Galphimia [10].

Achieving a balance to minimize bias as much as possible, in a double-blind placebo trial, involves both study arms receiving equivalent visit time and standard care. Participants should be blinded to the type of preparation, and assessors should be blinded to the type of preparation as well. It is expected that participants would be sensitized to perennial allergens that cause Rhinitis and would have persistent, Rhinitis symptoms throughout the study period. The primary endpoint should include use of a reflective tool to measure differences in TNSS and Rhinology Quality of Life Questionnaires (RQLQ) in the 4 to 8 weeks' time period. Utilizing clinically relevant differences would help define how participants would experience improvement, as would the use of a rescue medication. Use of a placebo would help capture expectation effect of consultation as well as remedy.

5. Limitations:-

The review is constrained by a small, explicitly tracked source set and does not represent a registered, exhaustive, multi-database systematic search. Primary reports span various Time Periods, Disease Phenotypes, Controls, Potency Regimens, and Endpoints. Some of the evidence is only available at the abstract level. The 2026 planned head-to-head trial recruited fewer patients than intended and studied seasonal disease. Before-after observational studies cannot demonstrate comparative efficacy. Sufficient study-level standard deviations and comparable perennial-specific studies were not available to permit a de novo meta-analysis, assess I^2, or construct a pooled forest-plot diamond. Formal certainty grading remains constrained by reporting limitations and indirectness.

6. Conclusion:-

Galphimia Glauca is not supported by current evidence to be more effective than Individualized Homoeopathy for Perennial Allergic Rhinitis. The best available evidence is a planned head-to-head trial to evaluate Seasonal Allergic Rhinitis for which no significant benefit was observed for either arm. Other recent reports are for Different Comparators, Unspecified Allergic Rhinitis, and/or Observational, and cannot address the target comparison. Future head-to-head trials for Perennial Allergic Rhinitis should use concealed allocation, masked outcomes, and responders; and should adjust for, and report, other therapy and all adverse events. These would also help inform the field. Until then, claims should remain qualified, and evidence-based interventions for Rhinitis should not be replaced.

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