Homoeopathic Interventions for Cutaneous Warts: A Systematic Review and Evidence Synthesis Across Clinical Types.

Abstract:

Background: Cutaneous warts are proliferations of epithelial cells induced by human papillomavirus, with spontaneous resolution and recurrence that can be associated with psychosocial impacts and varying levels of discomfort. Though homeopathic treatments are used in these cases, their clinical use must be measured against controlled evidence and the course of wart pathology. The objective was to analyze homeopathic treatments for different types of cutaneous warts and examine the level of evidence justifying a formal systematic review. Methods: A systematic literature search was conducted for articles published from January 1, 2000, to July 31, 2026, in the following databases: PubMed/MEDLINE, Google Scholar, Crossref, DOAJ, AYUSH, and CCRH, the Indian Journal of Research in Homoeopathy, other citation trails and provided articles; with the last search conducted on August 1, 2026. Papers describing a randomized clinical trial or a clinical case series of a minimum of three cases were included. Evidence was evaluated based on the RoB 2, ROBINS-I, the JBI case-series appraisal, and GRADE. Results: A total of twelve publications based on ten different studies were included. These studies consisted of one placebo trial and nine studies with no control, two of which were companion studies to a cohort of one hundred patients. The featured randomized trial (n=60) and nine other studies with no control, reported a significant improvement in clearance rates, including 70/100 favorable responses for one large cohort study, though in these studies there were no defined outcomes, long delays in follow up, and no evaluation of adverse events. Improvement was observed in the Thuja sub-group, which was a concentrated portion of the main cohort; no other eligible studies on anogenital warts were found. Conclusion: Observational studies do report possible clinical improvement, and the controlled studies do not assess efficacy. The overall certainty was considered to be very low, with the lack of considerable evidence supporting the need for well designed, large, and adequately powered randomized clinical trials to prove efficacy.

Keywords: Cutaneous warts; Homoeopathy; Verruca vulgaris; Systematic review; PRISMA

1. Introduction

Cutaneous warts are harmless proliferative skin lesions that arise as a consequence of HPV infection of epithelial keratinocytes. A wart's morphology is affected by the viral type and location, as well as the host's immune response and the type of mechanical pressure that is applied to the lesion. Common warts, which are hyperkeratotic papules, usually appear on the hands and the skin around the nails. In the case of warts on the plantar surface, lesions can be painful and warts can merge to create mosaic plaques. Flat warts are less pronounced and are often located on the face and extremities. Warts around the face and neck are called filiform and present as elongated, wart-like projections. Involvement of the subungual and periungual regions is often disruptive to the nails and is difficult to treat. A separate evaluation for anogenital warts is warranted due to different methods of diagnosis, transmission, therapies, counseling, and differential diagnoses when compared to typical cutaneous warts (CDC, 2021; Zhu, 2022).

Evaluating treatment for warts is complicated by the natural history of the condition. In most cases, warts spontaneously regress, but warts can persist for years, and symptoms such as autoinoculation, recurrence, pain, and bleeding can lead to social anxiety and concern about the cosmetic appearance of the affected skin. The diagnosis of a cutaneous wart is usually clinical. However, rapidly emerging, ulcerated, and treatment-resistant warts that have an atypical appearance may require a biopsy. Other skin lesions such as calloses and corn, as well as seborrheic keratosis, skin tags, condyloma lata, and verrucous carcinoma may be confused with warts. Molluscum contagiosum is also often confused with warts, but this lesion is caused by a poxvirus (AAD, 2025; DermNet, 2025).

Management strategies are customized based on a number of factors including lesion type, site, number, patient age, immune status, discomfort, cost, and preference. Salicylic acid and cryotherapy are frequently employed. Other therapies including curettage, electrosurgery, laser, and several forms of immunotherapy and topical or intralesional treatments, are considered for stubborn cases. There is no ideal treatment and destructive methods can result in various adverse effects such as pain, blisters, discoloration, scarring, and lesions may recur (Friedman, 2021; Ringin, 2020; Truong et al., 2022).

In Homoeopathy, there may be an individualized, constitutional, and Homoeopathic prescription, a prescription based on the characteristics of the lesion, or an intercurrent remedy of Thuja occidentalis. The available studies documented everything from case reports to a small, randomized, and pilot study. Due to the nature of uncontrolled studies of warts, which focus on spontaneous regressions and cases reported selectively, and cases that received concurrent therapies, it is not appropriate to claim that the remedy was the cause of a good result. For these reasons, this study focused on the clinical type and remedy, outcome, bias, and the possibility of a meta-analysis.

2. Methods

Protocol and reporting standard

This review was delivered according to the PRISMA 2020 and PRISMA-S standards (Page et al., 2021; Rethlefsen et al., 2021). We provide a protocol but do not intend it to be registered in PROSPERO; there is no registration number.

Eligibility criteria

Populations that could be included were children or adults with the presence of cutaneous warts either clinically or histologically diagnosed. Anogenital warts could be included as a separate subgroup. Included interventions were individualized, constitutional, remedy-specific, or intercurrent homeopathic treatment. Comparators could be placebo, no treatment, standard care, or a pretreatment state. Included were randomized and non-randomized comparative studies, prospective or retrospective cohorts, and case series with a minimum of three participants. Single case reports were collected but were excluded from the primary synthesis. The following were excluded: Molluscum contagiosum, skin tags, corns, calluses, seborrhoeic keratosis, condylomalata, verrucous carcinoma, non-homeopathic botanical extracts, and non-HPV lesions.

Information sources and search

From January 1, 2000, to July 31, 2026, searches were performed at the following locations: PubMed/MEDLINE, Google Scholar, Crossref-linked records, the Directory of Open Access Journals, AYUSH and resources from the Central Council for Research in Homoeopathy, the Indian Journal of Research in Homoeopathy, and journal portals, as well as document reference lists and provided DOIs. The last search was performed on August 1,

2026. Direct searches at Scopus and Web of Science were reported as unavailable. No language restriction was applied, but a full English text or a detailed English report was required for extraction. A sample Boolean search was: ("warts" OR "cutaneous warts" OR "viral warts" OR "verruca vulgaris" OR "verruca plana" OR "plantar warts" OR "periungual warts" OR "anogenital warts") AND ("homeopathy" OR "homoeopathy" OR "individualized homeopathic treatment" OR "Thuja occidentalis" OR "Causticum").

Study selection and data extraction

Potential records were identified with a manual review log. Duplicate entries of DOI numbers, titles, authors, and cohorts were eliminated. Titles and abstracts were screened and full-texts were assessed. Fields were extracted for country, setting, study design, sample size, age, type of wart, type of intervention, type of comparator, type of treatment, treatment duration, follow-up, outcome definition, clearance or improvement, attrition, recurrence, adverse events, and funding or ethics reporting. Because Google Scholar and several journal portals do not publish reproducible export totals, PRISMA total counts refer to records retained in the review log and not all results published by those platforms.

Outcome Definitions and Synthesis

Primary outcomes were defined as complete clearance and significant or moderate improvement, as well as change in wart number or size and time to resolution. Recurrence, discontinuation, and adverse events were secondary outcomes, as well as quality of life and additional treatment. Wilson confidence intervals were employed for descriptive proportions. For meta-analysis, at least two independent studies were required with similar outcomes and that reported numerators and denominators that could be extracted. Heterogeneous uncontrolled case series were excluded from analysis, along with the placebo-controlled trial, which reported medians instead of a compatible binary outcome.

Overlap, risk of bias, and certainty

Reports were examined through their authors, clinics, length of recruitment, distribution of demographics, sample size, interventions, and outcome categories. The Thuja report, with a sample of 62, and the conference paper were paired with the report of the 100 samples parent cohort, and treated as a paired report. The domains of RoB 2 were used to assess risk for the randomized trial. For non-randomized evidence, the ROBINS-I tool, along with the JBI case-series checklist, were considered (Munn et al., 2020; Sterne et al., 2016).

Certainty was assessed for each outcome according to the GRADE approach. Due to serious bias, imprecision, inconsistency, indirectness, and potential publication bias, the level of certainty for observational studies was assessed as low.

Table1PICOS Eligibility Criteria

Domain	Included	Excluded or handled separately
Population	Children, adolescents, and adults with clinically or histologically diagnosed cutaneous warts; anogenital warts as a separate subgroup.	Non-HPV lesions; uncertain diagnosis without adequate clinical description.
Intervention	Individualized, constitutional, remedy-specific, or intercurrent homeopathic treatment.	Herbal or botanical extracts not used as homeopathic preparations.
Comparator	Placebo, no treatment, standard care, conventional treatment, or pretreatment condition.	None solely because a comparator was absent; uncontrolled evidence was retained but appraised cautiously.
Outcomes	Clearance, improvement, lesion number or size, time to resolution, recurrence, discontinuation, adverse events, DLQI.	Narrative claims without patient-level or group-level clinical outcomes.
Study design	RCTs, non-randomized comparative studies, cohorts, and case series with >=3 participants.	Single case reports from the primary synthesis; reviews, protocols, and opinion articles.
Conditions	Common, plantar, flat, filiform, periungual/subungual, mosaic, facial, resistant, and anogenital warts.	Molluscum contagiosum, skin tags, corns/calluses, seborrhoeic keratosis, condylomalata, verrucous carcinoma.

Note. PICOS = population, intervention, comparator, outcomes, and study design; RCT = randomized controlled trial; DLQI = Dermatology Life Quality Index.

3. Results

The manual search log recorded 52 retained candidates. Of these, 31 were identified from database or search platform queries, and 21 were found in the supplied articles, citation searches, and journal portals. Sixteen duplicates were identified, and the remaining 36 were screened for title and abstract selection. Seventeen were excluded for being unrelated to warts, for not being clinical treatment studies, or for not being homeopathic. Nineteen were

followed; one incomplete citation was not available. Of the remaining 18, six were excluded: four were single case reports, and the other three were a non-homeopathic Thuja article and a study conducted prior to the year 2000. The remaining studies, a total of 12, described 10 different studies. Of these, two described studies for which structured, quantitative information was available. However, the studies were not amenable to a pooled meta-analysis.

The evidence included a single randomized, double-blind, placebo-controlled homeopathic pilot study (n = 60), a large, uncontrolled study of 200 patients, and an uncontrolled study of 100 patients that was described in two companion publications, as well as several case reports of 50, 14, 8, 6, 5, 4, and 3 participants. Most of these studies were conducted in India. A variety of warts were studied, including common warts, flat warts, plantar warts, filiform warts, facial warts, warts on the fingers and around the nails, and mixed cutaneous warts. Very little studied warts were subungual or mosaic, and no studies of anogenital warts were found. The homeopathic remedies used included Thuja occidentalis, Causticum, Natrum muriaticum, Dulcamara, Antimoniumcrudum, Nitricumacidum, Sulphur, Staphysagria, Lycopodium, Sepia, Heparsulphuris, Arsenicum album, Lachesis, and others which were selected through case individualization.

In a pilot study involving a randomized control trial, 30 participants were assigned homeopathic treatment and 30 were assigned placebo for three months, after which seven participants were lost to follow-up. At the three-month mark, comparisons on the number and size of warts, and the Dermatology Life Quality Index, showed no significant difference, with wart number $p = .741$, wart size $p = .515$, and DLQI $p = .935$. Due to the small effect sizes, the authors of the study rated the efficacy as unclear and the study mainly as a feasibility study (Dey et al., 2021). However, due to the assisted nature of the study, the finding holds greater causal weight compared to previous studies that reported on the clearance of warts, without any assistance.

In this study, which had 200 participants, homeopathy prescribed Thuja, Dulcamara, or Natrum muriaticum, and was based on the clinical pattern. It noted that, after one month, 88% participants experienced remission, which was noted to be complete after three months. 12 participants experienced a delayed response, and 12 participants withdrew from the study. This report did not present a comparator, and claims it made on transmission and malignant

transformation were unsupported with the study design, thus these claims were omitted in this synthesis (Shraddhamayananda, 2017).

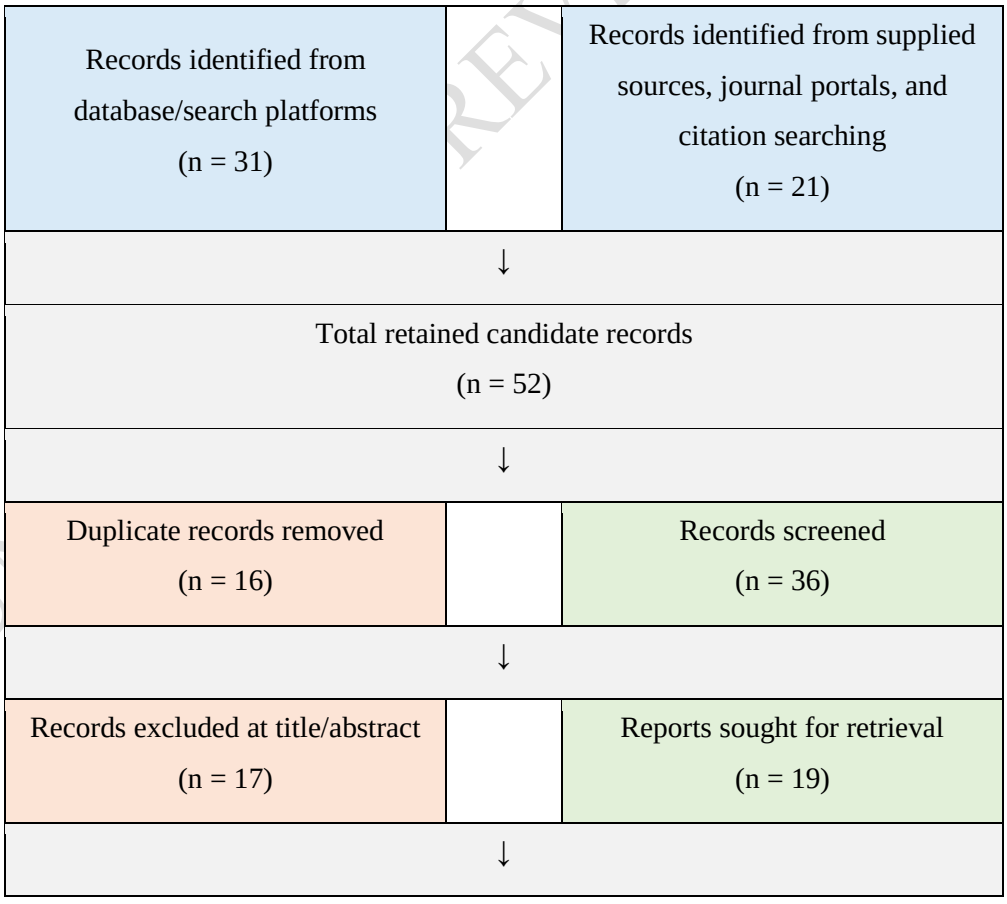
From the 100-patient individualized cohort, 70 had their responses as favorable, including 56 significant improvement, 14 moderate improvement, and 12 status quo, with the remaining 18 having had their therapy discontinued. This results in a descriptive positive response proportion of 70.0% (Wilson 95% CI 60.4%-78.1%). A related report included 62 participants of whom 37 had significant improvement, 8 moderate improvement, and 7 status quo, with the remaining 10 having had their therapy discontinued. This results in a positive response proportion of 72.6% (95% CI 60.4%-82.1%). The same setting, sample structure and demographics, outcome measures, and authors (and hence, no overlap in authors) referred to in the conference report (with recourse to the parent cohort) (Lathia & Patel, 2024, 2025; Lathiya et al, 2025).

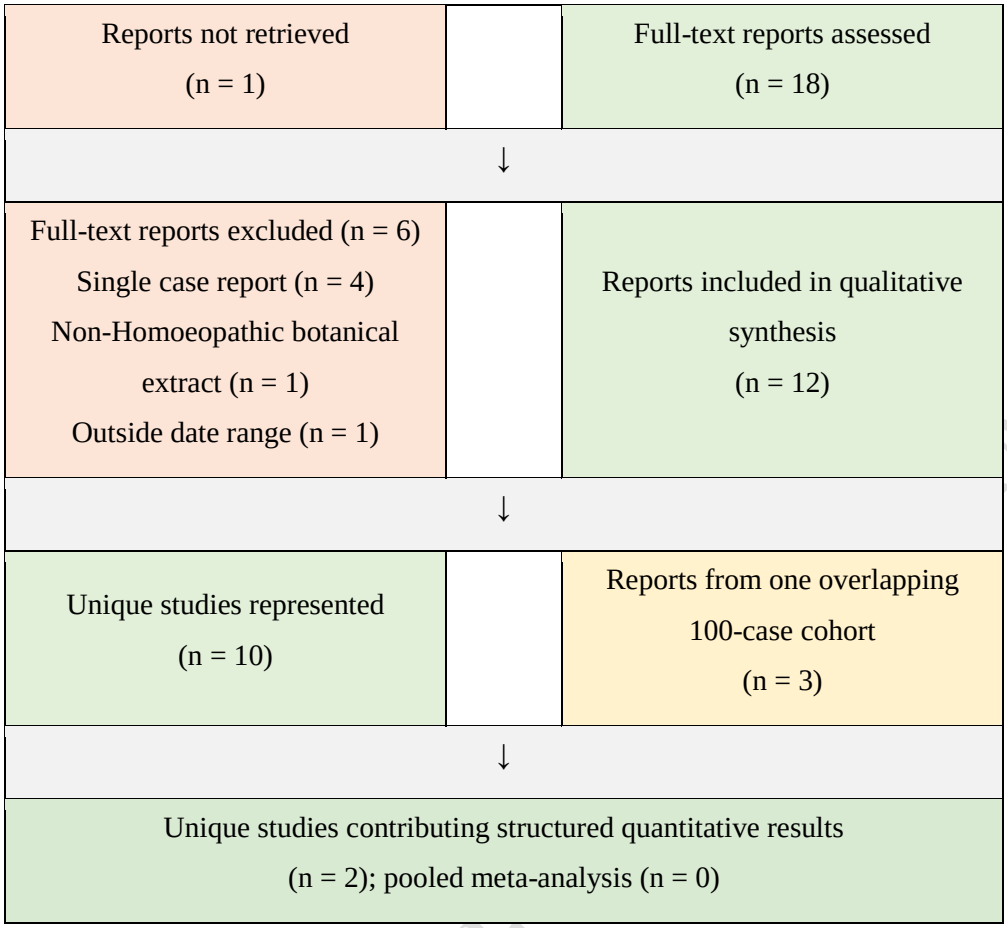
There was improvement and even clearance of symptoms following the therapy in the smaller case series and, in most instances, this was documented photographically. Dastagiri et al. (2023) documented 14 cases with follow-up of 2 to 5 years, complete resolution of therapy in 8 cases was documented by Choudhary et al. (2024) with follow-up of about 4 months, and Rath and Thakur (2024) reported on 6 cases which resolved after 2 months of follow-up, with no further recurrences. Biswas et al. (2022) reported favorable outcomes in 4 cases, and Shaikh (2016) and Das and Paramanya (2023) in 5 and 3 cases, respectively. These series had no concurrent controls and only selected completed (and hence successful) cases, which resulted in an outcome measure high to critical level of

Risk of bias was low to moderate for randomization and blinding in the pilot, but bias for attrition, small sample size, and imprecision was still concerning. All uncontrolled studies were classified as high or critical risk for causal inference due to a lack of comparators, spontaneous regression, subjective/non-standard/outcomes with incomplete consecutive-enrolment, selective reporting, and inconsistent safety surveillance. If recurrence was assessed at all, it was usually done so in a cursory fashion. Adverse events were usually characterized as absent, but the details of active surveillance were rarely provided. GRADE evaluations provided low certainty for the controlled continuous outcomes, and very low certainty for the outcomes of clearance, recurrence, and safety across the broad evidence base.

Outcome reporting issues also precluded a conventional meta-analysis. The pilot trial reported outcomes as medians and interquartile ranges for number of warts present, size of warts, and the Dermal Quality of Life scale. The large observational cohort used investigator-defined categories of improvement, and the study with 200 participants provided a report on the timing of remission with no clearly defined final numerator, or endpoint, in a quantitative form. Uncontrolled studies provided little to no information aside from a few selected case narratives. To create a common binary outcome from these diverse outcome reports would require unsupported assumptions on our part. In addition, a pooled proportion from the uncontrolled studies would essentially report the proportion of patients in the studies with documented improvement, and would not provide a comparative outcome of homeopathy. For these reasons, a quantitative meta-analysis was limited to the planned descriptive forest plot and a direct report of the between-group outcomes of the randomized trial.

Figure 1PRISMA 2020 Flow Diagram





Note. Counts refer to candidate records manually retained in the review log, not all search-engine hit counts. Companion reports were linked to the same underlying cohort.

Table 2Characteristics of Included Reports

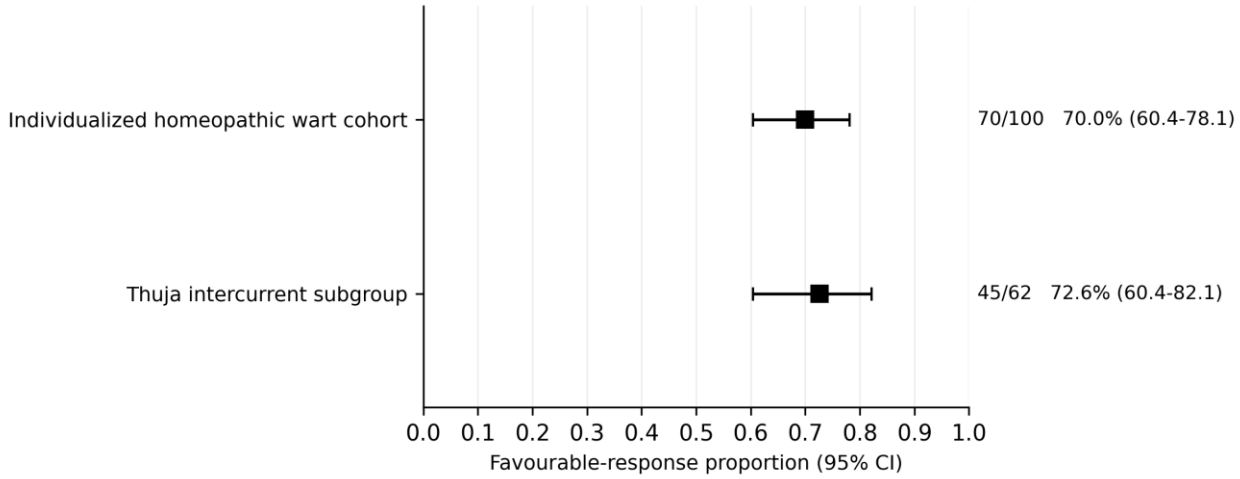
Report	Design/setting	Wart type	N	Intervention/comparator	Follow-up	Outcome measure	Main finding
Dey et al. (2021)	Double-blind pilot RCT; hospital OPD, India	Cutaneous warts	60	Individualized homeopathy (30) vs placebo (30)	3 months	Wart number, size, DLQI	No significant between-group differences; 7 lost; no serious harms reported.

Report	Design/setting	Wart type	N	Intervention/comparator	Follow-up	Outcome measure	Main finding
Shraddhamayananda (2017)	Uncontrolled clinical study; charitable dispensary, India	Common, plantar, flat/mixed	200	Thuja, Dulcamara, or Natrum muriaticum; no comparator	3 months+	Remission timing	88% began remission within 1 month; 12 delayed; 12 discontinued; no control.
Dastagiri et al. (2023)	Retrospective/clinical case series; institute OPD, India	9 common, 4 flat, 1 plantar	14	Individualized remedies; no comparator	2-5 years reported	Photographs, MONARCH	All cases described as resolved/improved; no recurrence reported.
Choudhary et al. (2024)	Case series, India	Mixed cutaneous sites/types	8	Eight individualized remedies; no comparator	~4 months	Photographs, MONARCH	Complete resolution reported in all; no recurrence during follow-up.
Lathia & Patel (2025)	Observational case series; private clinic, India	Mixed viral warts; genital excluded	100	Constitutional plus intercurrent remedies; no comparator	3 years recruitment; follow-up NR	Categorical improvement	56 significant, 14 moderate, 12 status quo, 18 discontinued.
Lathiya et al. (2025)	Retrospective subgroup report; same clinic/cohort	Verruca vulgaris/mixed	62	Thuja intercurrent subgroup; no comparator	NR	Same categorical outcomes	37 significant, 8 moderate, 7 status quo, 10 discontinued; overlaps parent cohort.
Lathia & Patel (2024)	Conference report; same clinic/cohort	Mixed viral warts	100	Same individualized/intercurrent approach	NR	Same categorical outcomes	Companion/duplicate report of parent 100-case cohort.

Report	Design/setting	Wart type	N	Intervention/comparator	Follow-up	Outcome measure	Main finding
Lathia et al. (2025)	Observational clinical review; private clinic, India	Verruca vulgaris	50	Causticum; no comparator	5-year clinical period; follow-up NR	Narrative clinical response	Outcome numerator not extractable; possible cohort overlap unresolved.
Rath & Thakur (2024)	Case series, India	Verruca vulgaris	6	Individualized remedies; no comparator	2 months after resolution	Photographs, MONARCH	Complete resolution and no recurrence reported.
Shaikh (2016)	Case series, India	Mixed warts	5	Individualized remedies; no comparator	Variable	Clinical/photographic follow-up	Clearance or marked improvement reported in all cases.
Biswas et al. (2022)	Case series, India	2 filiform, common, horny wart	4	Heparsulph., Arsenicum alb., Natrum mur.; no comparator	40-45 days	Clinical/photographic follow-up	Clearance reported in all; adverse effects not reported.
Das &Paramanya (2023)	Case series, India	Mixed cutaneous warts	3	Thuja and Causticum; no comparator	Up to 6-7 months	Clinical/photographic follow-up	Disappearance reported in all three cases.

Note. NR = not reported; OPD = outpatient department; MONARCH = Modified Naranjo Criteria for Homoeopathy. The conference and Thuja reports are companion publications of the 100-patient parent cohort.

Figure 2Reported Favourable-Response Proportions in Observational Homoeopathic Wart Reports



Note. The Thuja sample represents a clinically selected subgroup of the larger 100-case cohort and is displayed separately for descriptive purposes. The estimates were not pooled because participant overlap would violate the assumption of independent study samples.

Report	Improved	Total	Proportion	Wilson 95% CI
Individualized Homoeopathic wart cohort	70	100	70.0%	60.4%-78.1%
Thuja intercurrent subgroup	45	62	72.6%	60.4%-82.1%

Table 3Reported Remedies and Clinical Outcomes

Remedy/approach	Role	Number treated	Significant/complete	Moderate/partial	No improvement/ status quo	Discontinued	Recurrence/adverse events
Individualized medicines (Dey trial)	Constitutional individualized arm	30	Binary clearance NR	Continuous changes reported	Between-group differences nonsignificant	3	No serious harms; recurrence NR
Thuja occidentalis (parent cohort subgroup)	Intercurrent remedy	62	37 significant	8 moderate	7 status quo	10	NR
All remedies in parent cohort	Constitutional + intercurrent	100	56 significant	14 moderate	12 status quo	18	NR

Remedy/approach	Role	Number treated	Significant/complete	Moderate/partial	No improvement/ status quo	Discontinued	Recurrence/adverse events
Thuja/Dulcamara/Natrum muriaticum	Predefined by clinical pattern	200	Complete remission by 3 months reported for most; exact numerator ambiguous	12 delayed response	NR	12	Safety monitoring NR
Individualized case series	Sepia, Causticum, Natrum mur., Thuja, Antimonium crudum, Nitricumacidum, Sulphur, Dulcamara, etc.	40 across six small series	Clearance/improvement reported in nearly all published cases	NR	NR	NR	Follow-up variable; adverse-event methods limited
Causticum report	Remedy-specific	50	NR	NR	NR	NR	NR

Note. Unavailable outcomes are shown as NR rather than zero. Counts across small case series should not be interpreted as a pooled response rate because recruitment and reporting were heterogeneous.

Table 4Risk-of-Bias and Evidence-Certainty Summary

Evidence group	Selection	Confounding	Outcome measurement	Attrition	Selective reporting	Cohort overlap	Overall bias	GRADE certainty
Dey et al. pilot RCT	Low/some concerns	Controlled by randomization	Some concerns; objective dimensions but small pilot	Some concerns (11.6%)	Some concerns	None identified	Some concerns	Low for wart number/size/DLQI
100-case parent + companion reports	High	Critical; no comparator/spontaneous regression	High; nonstandard categories	High (18%)	High	Confirmed across three reports	Critical for causal inference	Very low

Evidence group	Selection	Confounding	Outcome measurement	Attrition	Selective reporting	Cohort overlap	Overall bias	GRADE certainty
200-case predefined-remedy study	Unclear/high	Critical; no comparator	High; remission definitions incomplete	Some concerns (12 discontinued)	High; unsupported causal claims	None identified	Critical for causal inference	Very low
Causticum 50-patient report	High/unclear	Critical; no comparator	Critical; response numerator unavailable	Unclear	High	Possible, unresolved	Critical for causal inference	Very low
Small case series (n=3-14)	High; likely selected cases	Critical; no comparator	High; photographs often unblinded	Unclear/variable	High publication bias	None proven	Critical for causal inference	Very low
Recurrence outcome	-	-	Short/inconsistent follow-up	-	Likely under-reported	-	Serious limitations	Very low
Adverse events	-	-	Active surveillance rarely described	-	Likely under-reported	-	Serious limitations	Very low

Note. Risk judgments concern the ability to infer a causal treatment effect, not whether the reported patient histories were genuine. GRADE certainty is outcome-specific.

4. Discussion

This review identified a significant contrast primarily between controlled and uncontrolled evidence. The only eligible modern randomized controlled trial (RCT) did not report a statistically significant between-group difference regarding the number of warts and their size, and the assessed quality of life did not show statistically significant differences. Conversely, the majority of uncontrolled case series reported significant or total improvement. The identified difference is clinically meaningful. In the case series, warts may regress spontaneously. Since this is an uncontrolled study design, case series cannot differentiate the effect of a treatment from natural regression, expectancy phenomenon, other simultaneous treatment(s), and measurement or assessment bias or selective reporting of

responders. While a case series can describe a phenomenon or a new treatment and generate hypotheses, it cannot demonstrate treatment efficacy.

There was also inconsistent measurement in the described outcome of the analyzed studies. Terms such as "significant improvement," "moderate improvement," "cured," and "complete remission" were not quantified or qualified. Improvement was not assessed in a systematic way, as it was not evaluated by a measurement of lesion count, standardized photographs, assessments conducted by individuals blinded to the study, or using a defined and agreed-upon threshold. In fact, the intentionally incomplete reporting of measures was sometimes confused with lack of improvement or treatment nonresponse, leading to an overstatement of the measure as a complete case. The cited example of the 100 patients study shows that among the reported participants, the remaining 70% were assigned to the “positive improvement” category, creating misleading reporting, as the measure was a composite of significant and moderate improvement. The associated publication on Thuja cannot be considered a study to confirm findings of the cited study, as it is a subgroup of the same study sample.

The selection of remedies exhibited significant variability. Some studies opted to personalize the treatment plan based on the totality of the symptoms, whereas other studies opted to use remedies based on the morphology of the warts and utilized other remedies either preceding or concomitantly with the constitutional remedy. While this diversity in the clinical approach may be an element of homeopathic practice, it results in considerable variability in the interventions and makes it virtually impossible to attribute outcomes to a specific remedy. The Causticum report included 50 participants, but no complete response denominator was presented in the available report, so it could not be included in the forest plot. Similarly, the other randomized study reported the medians for the continuous outcomes instead of the study’s clearance rate, which would allow it to be integrated with the uncontrolled studies.

The coverage of the various clinical presentations was uneven. Common warts were the main clinical presentation covered, while the other clinical presentations such as flat, plantar, filiform, facial and periungual warts were covered in mostly smaller studies. There was not enough evidence for subungual, mosaic, and treatment-resistant warts to warrant a conclusion pertaining to that clinical presentation. No study pertaining to anogenital warts

met the inclusion criteria. This is a significant gap as anogenital warts require a STI work-up, treatment and counseling. Merely removing the warts does not significantly lower the risk of HPV, nor does it prevent the transmission of the virus (CDC, 2021). Delays in the evaluation of anogenital warts that are persistent, or in the provision of age-appropriate and anatomy-based home-country guidelines, do not justify the use of homeopathic treatment.

Current principles of dermatological management recognize the individuality of patient care with the understanding that recurrence is a common outcome. Salicylic acid and cryotherapy have established utility for many common warts. However, diagnostic reconsideration and specialist approaches may be necessary for persistent warts (Ringin, 2020; Truong et al., 2022; Zhu et al., 2022). Therefore, when discussing these treatment options, it is important to understand the limits of evidence, and include red flags (e.g. persistent anogenital warts, bleeding warts, rapid growing warts, ulcerated warts, warts with changing pigmentation, warts in an immunocompromised patient, persistent anogenital warts, warts of uncertain diagnosis, warts that ulcerate and bleed). For atypical lesions, medical intervention is warranted; a diagnostic delay may necessitate removal of other lesions.

The evidence for safety also requires careful evaluation. Statements that no adverse effects have occurred have been reported, however, these studies oftentimes failed to provide the solicitations, lab evaluations, treatment-emergent adverse effects, or the denominator of time firmly remaining in safety studies. Highly diluted formulations may have a lower potential to be active pharmacologically, however, safety risks may be posed by product quality, other undisclosed/crossed ingredients, and diagnostic delays. This is very important for painful plantar lesions, lesions involving the nail unit, and lesions that may be malignant.

Future studies must implement multiple centers with randomized designs, allocation concealment, credible placebo or active comparators, independent outcome assessments, and intention-to-treat analyses. They ought to classify by wart type and immune status and clarify if local treatments are allowed, as well as specify total clearance, lesion count, lesion area, time to clearance, DLQI, side effects, and recurrence at 6 months and 1 year, as well as treatment of recurrence. Blinded photographers will assess standardized photographs. Studies must also report their methods and results in accordance with the CONSORT guidelines, present transparent treatment algorithms, and disclose negative results. A sufficiently powered copy of the 2021 pilot study will be more helpful than uncontrolled responder series.

5. Limitations

This review was constrained by a small and heterogeneous evidence base and the reliance on a few journal platforms and recorded Google Scholars logs, as opposed to reproducible exports from every subscription database. Due to a lack of availability of Scopus and Web of Science, some papers reported incomplete methods, and one report had an inaccessible citation. Most of the studies were uncontrolled, retrospective, or selective case series. A blinded assessment, consecutive recruitment, standardized definitions for clearance, surveillance for long-term recurrence, and monitoring of adverse events were minimal or completely absent. Judgement was needed for a supposed overlap with three publications writing about the same cohort of 100 patients, and no overlap was ruled out between the 50-patient Causticum report and the author's other publications which came from the same private clinic. Considerable publication and language biases were present, as case reports and case series which presented a favorable outcome tended to be published more. The descriptive forest plot was used to present the proportions that were reported, but did not try to quantify a measure of comparative efficacy. While the 2020 to 2026 publications were prioritized, other older, eligible publications which were termed to be clinically meaningful were included. The results were intended to give a picture of the data which were available, rather than an attempted comprehensive search of all available data, as some regional or non-indexed studies were not included.

6. Conclusion

Homeopathic wart treatment studies suggest some improvement and clearance of warts, but there is a risk of spontaneous regression, selection bias, variable outcomes, dropout, and duplicate publications. The only modern placebo-controlled pilot study was not statistically significant and was considered inconclusive. Thus, the current body of evidence indicates that homeopathic treatment of warts is not better than placebo, waiting, or other conventional treatments. The level of certainty is very low concerning clearance, recurrence, and safety. More, multicenter, adequately powered clinical studies are needed, with the registration of the study protocol, controlled, standardized photography, blinded assessment of study endpoints by dermatologists, and an intention-to-treat analysis. This should be coupled with long-term studies of recurrence and adverse events. Patients with warts that are

different, bleeding, rapidly growing, pigmented, ulcerated, resistant, anogenital, or otherwise of concern should be evaluated by a clinician, and those with concerns for cancer should undergo a biopsy.

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