Role of LM Potency in the Homoeopathic Management of Migraine: A Systematic Review Unveiling Current Clinical Evidence, Therapeutic Applications, and Unaddressed Research Gaps.

Abstract:

Background: Migraine is a primary headache disorder. Some practices of individualized homoeopathy use LM (50-millesimal/Q) potencies and claim they allow repeated flexible dosing.

Objective: To evaluate the published clinical evidence from 2015 to 2025 on the management of migraine with LM-potency in homoeopathy, to identify the therapeutic applications, and to evaluate if it is justified to perform a quantitative synthesis.

Methods: Search of the literature according to the PRISMA 2020 guidelines and of scholarly indexes and publishers, access to the journal archives, supplementary citation search, and registers of clinical trials was conducted on 7 September 2026. The studies had to include human migraine, and explicit LM/Q/50-millesimal exposure, and have completed clinical outcomes published in the period 2015 to 2025. Case reports were assessed by the JBI (Joanna Briggs Institute) case report criteria; for the evaluation of comparative studies, tools appropriate to the design of bias risk would be applied.

Results: From the nineteen records examined, eleven reports or registry records were assessed for eligibility in full. One inclusive study of LM-potency migraine was published in 2024, a case report of an adolescent. It reported a five-year shift from Phosphorous 200CH to repeated Phosphorous LM8–LM13 along with an improvement of symptoms and a subsequent relapse. The authors reported a MONARCH score of +8, but explicitly stated that causality could not be determined. No eligible controlled LM studies provided a comparative effect estimate, thus meta-analysis, estimation of heterogeneity and publication bias were not possible.

Conclusion: The 2015–2025 period Provides clinical signals but not enough efficacy data for causal conclusion. Clinical trials of LM-specific migraine using valid endpoints are justified before the value in terms of effect, repetition and safety can be assessed.

Keywords: Migraine; Homoeopathy; LM potency; 50-millesimal potency; Q potency; Individualized homoeopathy; Systematic review; Meta-analysis.

1. Introduction

The International Classification of Headache Disorders, 3rd Edition (ICHD-3), presents the most advanced diagnostic criteria and classification of migraine. One population-based study documented that migraine contributes to an important burden of years lived with disability. Among GBD analyses, migraine was placed consistently among the first contributors to the burden of disability worldwide, with a particularly pronounced impact on young women (GBD 2016 Headache Collaborators, 2018; Steiner et al., 2020). Recent syntheses view migraine as a disorder with a Multifactorial Neurovascular component that includes the trigeminovascular system as well as interactions between the cerebral cortex and the brainstem and genetics (Ferrari et al., 2022).

The combination of evaluation, diagnosis and intervention, trigger management and lifestyle interventions, acute treatment and preventive interventions is the core of evidence based migraine care. Driven by the introduction of new preventive therapies for migraine and therapies directed against calcitonin gene related peptide (CGRP), most consensus and practice recommendations support the acquisition of recently developed acute migraine therapies and preventive therapies as well as existing therapies (Ailani et al., 2021; Charles et al., 2024; Puledda et al., 2024a, 2024b). Migraine care must be individualized for children and adolescents because of the differences when compared to adult care (Gibler et al., 2022; Al-Futaisi, 2023). The long-term care strategies will be dictated by the suboptimal tolerability and by the prolonged course of treatment (Hird & Sandoe, 2023).

Some patients combine homoeopathy with other therapies. Clinical literature has significant variability on the model of homoeopathy interventions, symptoms, comparative groups, and methodological quality. Meta-analyses of homoeopathy for several conditions have reached different conclusions based on the quality of individual trials and whether the treatment is individualized or standardized (Mathie et al., 2017, 2018, 2019; Hamre et al.,

2023). For migraine, these broad syntheses do not answer the question of potency, nor do they address the specific effectiveness of the condition. Safety syntheses are concerned with homoeopathy, not LM, as a treatment for migraine (Stub et al., 2016, 2022).

LM potencies, comprising a unique scale of preparations and doses, fall under the category of homoeopathic preparations and doses. Recent literature on homoeopathy states that LM potencies should be administered regularly and adjusted, although such regular administration and adjustment should not be considered a substitute for the study of clinical trials. For this reason, a review focused on migraine must carefully distinguish the three tiers of evidence. The first tier is published clinical studies on the use of LM potencies, the second tier is studies of migraine that are homoeopathic but do not include LM, and the last tier is studies of LM for other clinical conditions. Combining studies in different tiers would result in a potency-specific effect that the studies did not evaluate.

2. Objectives and Research Question

What were the clinical data from 2015 to 2025 on potency of LM/50-millesimal/Q with migraines, how LM dosing was used, and the gaps in the methodology that do not allow for definite answers? The PICO question is what are the results of individualized or prescribed LM-potency homoeopathic therapy on patients with clinically diagnosed migraines (P), when compared to placebo, usual care, another potency scale, active treatment, or a given baseline (C), concerning the frequency of migraines, the number of days of headaches, the intensity and the severity of headaches, the disability, the duration of headaches, the need for rescue medication, the quality of life, the recurrence, and the safety (O).

3. Materials and Methods

3.1 Review Design

This review has been reported according to the PRISMA 2020 (Page et al., 2021) guidelines, with reference to the recommendations for the synthesis of homoeopathic intervention studies (Gaertner et al., 2023). As the search identified case report data instead of a trial of LM, the case reports were evaluated according to the JBI criteria and the CARE reporting framework (Moola et al., 2020; Riley et al., 2017). Prior to the evaluation, the eligible studies of random or non-random comparative nature were assessed as RoB 2 or ROBINS - I. In ROBINS-I bias is attributed to confounding, selection, classification of the

intervention, deviations from the intervention, missing data, measurement of the outcomes and reporting of the outcomes (Sterne et al., 2016).

3.2 Eligibility Criteria

The publication date range was set to January 2015 to December 2025. Case reports describing participants who received an LM/Q/50-millesimal homoeopathic potency and whose migraines improved were acceptable. Acceptable case reports included randomized controlled trials, prospective studies, observational studies, and case reports. Case reports were not accepted if there was no exposure to LM or if there was no distinction among the other potency scales; if the case report did not contain information regarding the migraine; if the case report was theoretical or a review; if the case report was uncompleted; if the case report was an ongoing study without any results published; or if the publication date was outside the prescribed range.

3.3 Information Sources and Search Strategy

The last search was conducted on June, 2026. Scholarly web-indexes to locate peer reviewed literature, PubMed/MEDLINE, publisher and journal archives, backward citation checking, the Clinical Trials Registry - India via an indexed registry interface, and subscription-based databases that could not be searched were not represented as completed searches and were considered a review limitation. In the primary search the following Boolean terms were used: (migraine OR “migraine disorder*” OR headache) AND (homeopath* OR homoeopath*) AND (“LM potency” OR “LM potencies” OR “50 millesimal” OR “50-millesimal” OR “fifty millesimal” OR “Q potency” OR “Q potencies”). This search was limited to the years 2015-2025 and further limited with terms related to individualized treatment, MIDAS, HIT-6, migraine frequency and disability.

3.4 Study Selection and Data Extraction

The report log contained 23 records. Multiple records for the same publication were recorded and 4 duplicates were removed, leaving 19 records for the next phase of screening. Finally, 11 reports and registry records were selected for full length assessment. We collected data for author, year, country, study design, study participants and diagnostic criteria, interventions, intervention components, control, outcome measures, adverse event reporting, and conclusions. Data were copy transcribed were reported in the source. For data not reported, “not reported” (NR) was noted.

3.5 Statistical Analysis and Meta-Analysis Decision Rule

As a priori decision, if at least two comparative LM-specific studies included in the meta-analysis provided an effect estimate for a common continuous outcome, or for LM-specific outcomes on disparate continuous outcome scales, or for dichotomous outcomes, random-effects meta-analysis was to be performed. Standard mean differences and risk and/or odds ratios would be reported, and if applicable, it was expected to report 95% confidence intervals, study weights, Cochran Q, I^2, and τ^2. It was anticipated meta-analysis would be performed if the number of included studies was <10. Funnel-plot and regression-based assessments of publication bias were not expected due to the anticipated small number of studies, and pooling was to be performed even if study variance, effect size, or the event count was not available.

4. Results

4.1 Study Selection

The screening process is detailed in Figure 1. Of the 19 unique records, 8 were removed during the title and abstract screen because they were either non-migraine LM publications or narrative/review articles with inadequate clinical outcomes. Included in the final sample were 11 reports/registry records. Of the 11 migraine studies, 6 either didn't describe an LM/Q/50-millesimal intervention or used other potency ranges, and 2 of these left out a substantial portion of the clinical outcome; 2 of the 2025 Registrations were of ongoing LM-migraine trials without results. Of these, one completed LM-specific migraine study was included. This means the qualitative synthesis was comprised of one study, and the quantitative meta-analysis included no comparative studies.

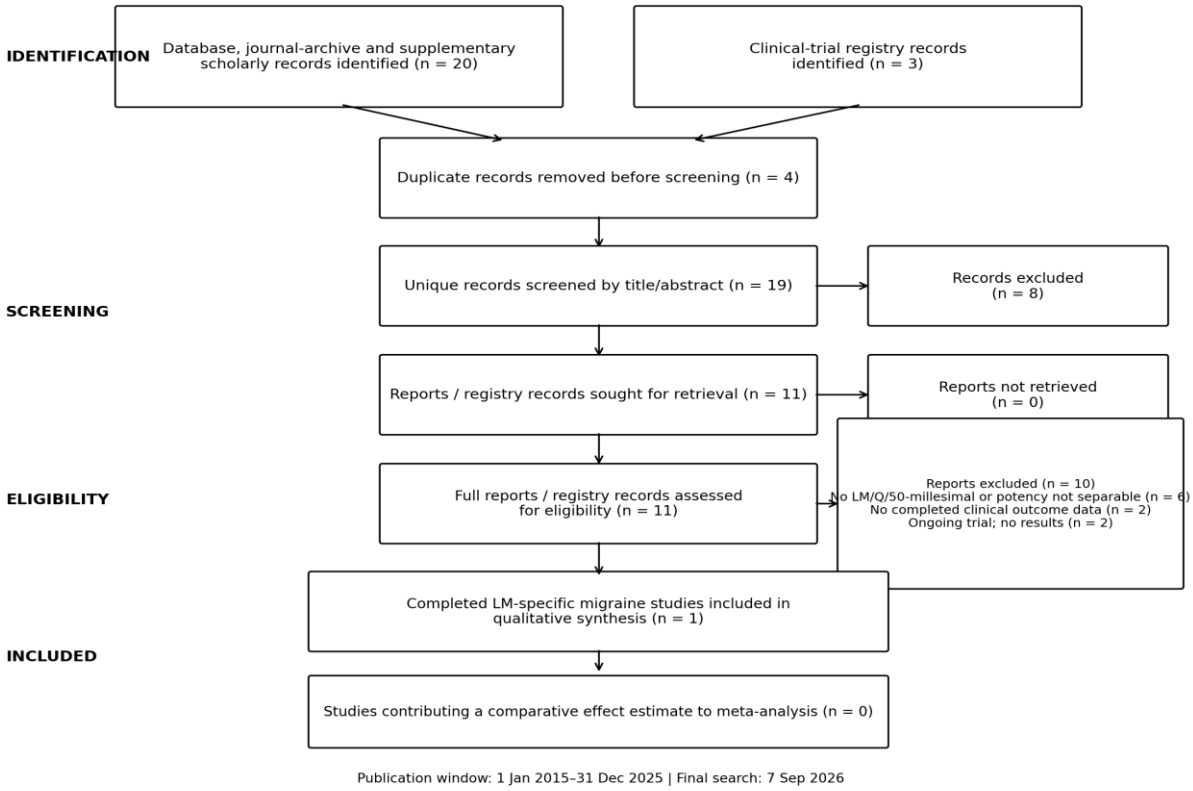

Figure 1. PRISMA 2020 flow diagram of study identification, screening, eligibility assessment, and inclusion. Counts reflect the documented search log; ongoing trial registrations were assessed for eligibility but were not treated as completed clinical evidence.

4.2 Characteristics of the Included Clinical Evidence

In Glas et al. (2024), an 11-year-old with migraine aura and a 9-mm septate pineal cyst was described. The patient had approximately 10 headache events over the period of 6 months prior to the first homeopathic consultation. During this period, she had taken paracetamol or ibuprofen, however continued to experience headaches for 2 days after conventional treatment. The case began in 2018 with Phosphorous 200CH. After the treating clinician associated relapses with triggers and insufficient stabilization, the following year, the patient was put on LM repeated doses. The authors reported the patient every 5 years. The authors reported improvements and later relapses, as opposed to a complete absence of symptoms.

Table 1. Characteristics of the included completed LM-specific migraine study.

Study	Design / participant	Migraine diagnosis	LM intervention	Comparator	Main outcomes

Study	Design / participant	Migraine diagnosis	LM intervention	Comparator	Main outcomes
Glas et al. (2024)	Case report; 11-year-old female; Slovenia/India-linked authorship	Migraine with aura; concurrent 9-mm pineal cyst	Individualized Phosphorous; LM8–LM13 used after earlier 200CH dosing	None	Periods without migraine, later milder relapses; VAS 8/10 at one 2022 relapse; final follow-up reported no migraine; causal effect not established

4.3 LM-Potency Therapeutic Application

The treatment with LM sequence was not protocol-standardized but rather clinically adaptive. Phosphorous LM8 and LM9 were each prescribed daily for 3 weeks, and LM10 and LM11 were prescribed on alternate days for 2 months. Frequent relapses in 2022 led to the use of LM12 and LM13. LM13 was later prescribed on alternate days. This case report demonstrates the clinical use of LM potency consistent with classical individualization. However, since the LM dosing was done after the patient had 200CH exposure and varied throughout the changing clinical conditions and without a control group, the case cannot credit the effects to LMs.

Table 2. LM potency, prescription and treatment characteristics in the included report.

Date	Clinical status	LM prescription	Reported outcome at/after follow-up
14 Feb 2019	Partial relapse after exertion	Phosphorous LM8 then LM9; each once daily for 3 weeks	By 9 Apr 2019, no headache or migraine reported
9 Apr 2019	No migraine/headache; herpes eruption	Phosphorous LM10 then LM11; alternate days for 2 months	Long interval before later milder headache episodes
1 Jul 2022	One migraine with aura after exertion; VAS 8/10	Phosphorous LM12 followed by LM13	Later one brief aura/mild headache episode
3 Nov 2022	Mild aura and 20-min headache	Phosphorous LM13 every alternate day	No migraine recorded 18 Jan and 7 Mar 2023

4.4 Critical Appraisal

The case report was relatively detailed and included the patient's point of view. The authors noted that the MONARCH criteria, in this case, was +8. They note that a case report cannot determine whether a change observed was the result of treatment. Of the major limitations from an evidence-synthesis viewpoint, the issues are more fundamental than incomplete reporting. In the absence of a comparator or counterfactual, there was no blinded assessment of the migraine endpoint, no prespecified migraine endpoint, and no actively monitored adverse events. Regression to the mean, natural fluctuation and changes, developmental changes, changes to the pattern and cause of the triggers, concurrent use of analgesics, the variation of placebo and context effects, and the natural history of the pineal cyst remain other likely explanations.

Table 3. JBI-oriented critical appraisal of the included case report.

Appraisal domain	Judgement	Rationale
Patient demographics	Yes	Age and sex were reported.
History and timeline	Yes	Longitudinal history and dated follow-ups were provided.
Clinical condition / diagnosis	Yes	Migraine with aura and imaging findings were described.
Diagnostic assessment	Yes	MRI and differential investigations were reported.
Intervention description	Yes, with limitations	Remedies, potencies and repetition were reported; treatment was adaptive rather than protocolized.
Post-intervention condition	Yes	Multiple follow-ups documented improvement and relapse.
Adverse/unanticipated events	Unclear	No structured adverse-event surveillance or predefined safety endpoint.
Take-away lesson	Yes	Authors explicitly called for further controlled investigation.

4.5 Meta-analysis, Heterogeneity and Publication Bias

No eligible study supplied a controlled LM-specific effect estimate. A single case report cannot provide a between-group mean difference, standardized mean difference, risk ratio or odds ratio; it also provides no study-level variance appropriate for inverse-variance weighting. Thus, a pooled effect, confidence interval, study weight, Cochran Q, I^2, τ^2, Z statistic and the meta-analytic p-value were not calculated. Sensitivity, subgroup and publication-bias analyses were also not meaningful. Figure 2 displays the forest-plot decision in a transparent way rather than giving a false effect estimate to the case.

Table 4. Quantitative meta-analysis decision and estimability.

Requested statistic	Status	Reason
Individual comparative effect size	Not estimable	Included evidence was one non-comparative case report.
Pooled effect and 95% CI	Not estimable	No two compatible comparative LM studies.
Study weights	Not estimable	No variance-based comparative estimates.
Cochran Q / I^2 / τ^2	Not estimable	Heterogeneity requires ≥2 study estimates.
Subgroup / sensitivity analysis	Not estimable	Insufficient number and diversity of eligible studies.
Funnel plot / Egger-type test	Not appropriate	Far fewer studies than required for meaningful assessment.

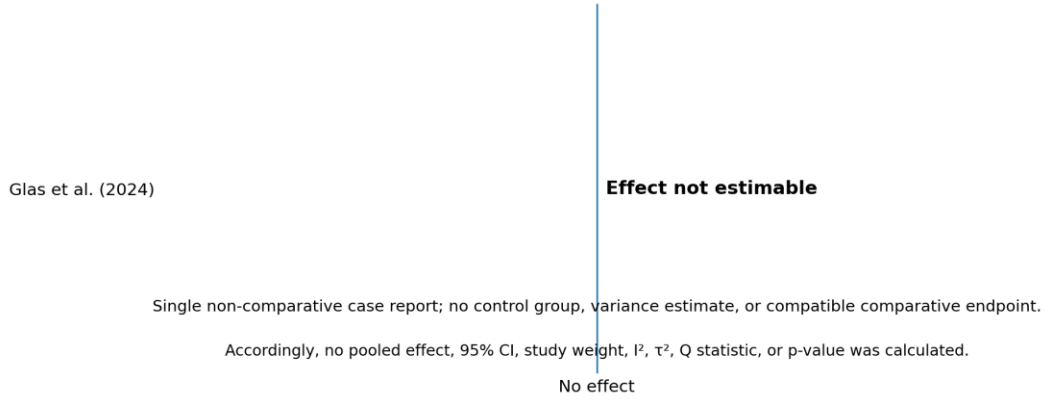

Figure 2. Forest-plot eligibility panel for LM-potency migraine outcomes. No pooled estimate was generated because no eligible controlled LM-specific effect estimate was available.

4.6 Near-Eligible Evidence and Research Pipeline

Several records show why our evidence base can appear larger than it is. One of these records is Mohanty et al. (2020). They randomized 60 patients with migraines to get either homoeopathic treatment or a placebo and used the HIT-6 tool. The publication did not identify treatment as LM/Q/50-millesimal potency and therefore cannot estimate an LM-specific effect. Kumari (2022) discussed 50-millesimal potency in the context of acupressure, but this article provided rationale and discussed the potential research significance rather than an actual clinical research dataset. Other migraine studies in the given timeframe either used a centesimal range or did not provide a separable LM exposure (e.g., Arya & Awasthi, 2025; Pandey & Mishra, 2025). Two 2025 CTRI records are of particular interest and are considered prospectively. CTRI/2025/08/092727 planned a migraine study using LM-potency with a target sample of 40, and CTRI/2025/08/093493 planned a comparison using an 80-participant sample of the centesimal and 50-millesimal scales. Their indexed records were not recruiting and did not have results when captured. Therefore, they were not included as effectiveness evidence.

Table 5. Key near-eligible and ongoing evidence relevant to LM potency and migraine.

Record	Design / status	Why not included in completed LM efficacy synthesis	Value for future evidence
Mohanty et al. (2020)	Single-blind placebo-controlled RCT; n=60	Migraine trial, but LM/Q/50-millesimal potency not identified	Shows feasibility of controlled migraine outcomes such as HIT-6
Kumari (2022)	Research-rationale article	Explicit 50-millesimal topic but no completed patient outcome dataset	Identifies proposed LM + acupressure research direction
Arya & Awasthi (2025)	Clinical study; n=38	Potencies reported as 30C to 1M, not LM	Illustrates use of MIDAS in homoeopathic migraine research
Pandey & Mishra (2025)	Retrospective case series; n=30	Best-described strategy used constitutional 200C, not LM	Highlights posology as a measurable design variable
CTRI/2025/08/092727	Registered interventional study; target n=40	Ongoing/no results in captured record	Direct LM-specific migraine trial
CTRI/2025/08/093493	Registered comparative RCT; target n=80	Ongoing/no results in captured record	Direct centesimal vs 50-millesimal comparison

5. Discussion

The main finding is lack of evidence, not a pooled efficacy estimate. Within the strict 2015–2025 timeframe, only one completed clinical report addressed migraine, and cited LM potency. The report includes interesting longitudinal clinical data: baseline of migraine with

aura, repeated LM dosing after switching from 200CH, multiple symptom-free intervals, and later less severe migraine with increasing symptomatic periods. Such data is useful for clinical cases, but has extremely weak validity. Case reports motivate clinical thinking and document clinical practices; they cannot assess cause and effect in clinical cases, or distinguish the effects of clinical cases from the natural course of a disease, expectation, regression to the mean, and the effect of concurrent interventions, measurement error, spurious or other time-related factors (Riley et al, 2017).

The reviewed literature also shows how difficult it is to assign potency to LMs. Unless studies prescribe an LM at a specific potency and examine the outcome at that potency, we cannot consider other general homoeopathic studies for migraines as evidence for LMs. For example, Mohanty et al (2020) has a clinically relevant HIT-6 outcome and also a comparative study, but they cannot answer the LM question. On the other hand, broader LM reports in chronic disease provide some data on the feasibility of dosing, but cannot establish the efficacy of migraine (Abarna et al, 2015). Similar reviews that state LMs are gentler or more repeatable are not clinical evidence of efficacy (Bhatia et al, 2025; Maurya, 2025). This helps us prevent a common error in integrative reviews: combining related, but non-equivalent evidence, to incorrectly support a conclusion at a specific potency.

The absence of meta-analysis is not a methodological flaw due to the absence of multiple estimates of a similar causal comparison. A case trajectory of a single individual without a comparator does not satisfy the previous criterion. Even if the estimate of the standard error, control rate, or pre-post correlation were reported, it would lead us to an arbitrary answer that is not supported by the data. The same reasoning can be used to assess heterogeneity: if only one non-comparable study is available, it is meaningless to report the values I^2 and τ^2. Sum-HomIS recommendations indicate that the methods of synthesis and the clinical case should be carefully considered, rather than taking an unstructured approach and pooling all the studies (Gaertner et al., 2023).

Clinical judgement should take into consideration the current state of migraine treatment. The more recent migraine treatment guidelines and consensus recommendations describe the existing evidence for acute and preventive treatment, along with migraine-specific therapies, and address the importance of personalization and control (Ailani et al., 2021; Charles et al., 2024; Puledda et al., 2024a, 2024b). The review under consideration does not provide evidence that LM has the same or higher effectiveness in the context of the treatments mentioned above. The review is also not able to make any statements about the impact of

repeated LM administration on the rate of rescue medication use, the number of monthly migraine days, the level of disability, or the occurrence of adverse events. Although general homeopathy safety reviews suggest that adverse events should not be reported based on the level of dilution (Stub et al., 2016, 2022), the safety of LM in the context of migraine safety is still undetermined.

The two 2025 trial registrations are therefore important. A direct LM study and a centesimal versus 50 millesimal comparisons could provide the next advancement of the field from descriptive to comparative studies, if recruitment, adherence to the protocol, and reporting are completed. For such studies to be informative, selection of potency and progression must be made before the study or at least demonstrated after; outcome assessors should be blinded as much as possible; and validated migraine endpoints should be documented at pre-defined points. Monthly migraine days, attack frequency, pain intensity, MIDAS or HIT-6, days of medication used, responder thresholds, and adverse events would provide sufficient endpoints for meta-analysis and clinically interpretable data. Trial registration and reporting are essential, especially in treatments that are individualized, as analytic flexibility in such cases can result in amplified selective reporting.

6. Clinical and Therapeutic Implications

The available literature supports only a descriptive statement: LM potency has been used in an individualized migraine case with repeated dosing and progressive potency changes. It does not support a population-level estimate of benefit, an optimal starting LM potency, an optimal repetition interval, or superiority to centesimal prescribing, placebo, or standard treatment for migraine. Clinicians should continue to make the evidence-based diagnosis of migraine and manage with effective acute and preventive care, regardless of the use of homoeopathic treatment. LM, when selected by patients, should be discussed within the context of preventive migraine treatment as an adjunctive therapy rather than a replacement as it falls short of evidence-based treatments.

7. Unaddressed Research Gaps

Priority gaps include randomized control trials unique to LMs in migraine studies, insufficient reporting of potency in migraine studies, inconsistent LM dosing algorithms,

small sample sizes, no blinded, between-group assessments of outcome, insufficient monitoring of adverse events, limited reporting of migraine measures, and a lack of published studies on LMs. Long-term recurrence, rescue-medication use, quality of life, and subgroup effects by aura status have received little, if any, attention. There are insufficient data to differentiate LM size effects from the effects of consultation, individualization, remedy selection, natural changes, conventional treatment, or the placebo.

In order to establish a foundation for future synthesis, it is imperative that the LM scale, starting and ending potencies, repetition schedules, doses that were adjusted, co-medications, the migraine diagnostic criteria, and outcome measures that are measurable at the end of the intervention are all published. Trials also must publish the absolute value change and the outcome as a group comparison with the estimate of variation. Without these research components, it is virtually impossible to compare and/or combine the published studies. This is especially relevant when considering individualized homeopathy, where selection of the homoeopathic remedy differs for each participant. Publishing the design of the study, deviations from the published protocol, and reporting in a detailed way facilitates making the distinction between the selection of the homoeopathic remedy and the potency scale.

Table 6. Current evidence gaps and recommended research responses.

Evidence gap	Why it matters	Recommended response
No completed LM-specific RCT	Causality and comparative effectiveness cannot be estimated	Preregistered, adequately powered multicenter RCT
Potency poorly reported in migraine studies	Prevents LM-specific attribution and synthesis	Report exact scale, potency progression, dose and repetition
Inconsistent outcomes	Prevents cross-study pooling	Use monthly migraine days plus MIDAS/HIT-6, VAS/NRS and medication use
No standardized safety surveillance	Tolerability cannot be quantified	Prospective adverse-event definitions and reporting
Individualization creates analytic complexity	Raises risk of selective decisions	Predefined analysis plan; document remedy changes and co-interventions
Limited long-term evidence	Durability and recurrence uncertain	Follow-up beyond active treatment with predefined relapse endpoints

8. Future Research Directions

Researchers should publish the 2025 LM-migraine studies in stone and conduct multicenter studies based on the ICHD-3 criteria and modern standards of migraine trials. Research should compare groupings of LM and centesimal dilution while minimally changing the broader consultation model. Research plans should describe randomization, blinding, allowance for emergency medications, attrition rate, primary time points and multiplicity control. The selected individual remedies may be used, but the remedy potency,

the dose change and the reason for the dose change should be recorded. Research data that does not identify participants and the research code should be made available so that the research can be verified and that research could be used in future meta-analyses.

9. Limitations of This Systematic Review

A restrictive question was used to exclude general homoeopathic migraine studies that did not include exposure to LM. Although this did increase construct validity, it did decrease the number of studies. The search relied on PubMed/MEDLINE and the publications and archives of publishers and journals, scholarly index searches, and checking references and registers of clinical trials. The restriction of 2015 to 2025 also excluded older migraine-homoeopathy studies. Only one eligible completed report was found, which means that assessment of the certainty of the evidence and quantitative synthesis was impossible. These limitations are reported. No effort was made to address these limitations by using unverified data.

10. Conclusion

Findings from clinical studies during the time period of 2015 to 2025 were unable to confirm the effectiveness of LM/50-millesimal/Q potency for the treatment of migraine. One case report describes the use of progressive dosing of LM8-LM13, after previous treatments with centesimal dosing, in an adolescent patient and describes periods of relief with subsequent return of symptoms. The design of this report restricts any conclusions regarding a possible causal relationship and/or comparison; thus, it does not support any evidence of its effectiveness. In light of these results, no other eligible controlled LM studies reported any effect size. Consequently, no meta-analysis, forest-plot pooling, heterogeneity statistics, or assessment for possible publication bias were possible. Direct assessment of LM is forthcoming, as evidenced by two trial registrations in 2025. Until clinical trials of LM potency are published, LM potency must be considered an unsubstantiated therapeutic option for the treatment of migraine.

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