A Systematic Review of Therapeutic Efficacy of Robinia Pseudacacia versus Individualized Homoeopathic Intervention in the Management of Gastroesophageal Reflux Disease.

Abstract

Background: Gastroesophageal Reflux Disease (GERD) causes recurrent Heartburn, Regurgitation and decreased Quality of Life. Reports from Homoeopathic literature include treatment by use of Robinia Pseudacacia or Individually indicated remedies, but there is doubt about its effectiveness. Objective: To conduct analysis of specific clinical evidence on these interventions for GERD and see if direct comparison of their effectiveness is possible. Methods: Inclusion criteria were GERD population and Robinia-specific or Individualized Homoeopathic intervention. Information about study characteristics, endpoints and weaknesses was extracted. Published trial comparing other Homoeopathic medicine against placebo was analyzed separately as contextual evidence. Results: Five non-randomized clinical reports meeting criteria of target intervention have been identified. The Robinia group consisted of 30 patients; Individualized and multiple-remedies reports covered groups of 34, 40, 40 and 30 patients correspondingly. Several papers demonstrated within-group relief of symptoms but no head-to-head randomized comparison could be identified. The external randomized trial showed mean difference in GERD symptoms score of +1.10 (95% CI -0.56 to +2.76) for Acidil versus placebo; certainty of evidence was very low. Conclusion: No clinical trials establish superiority, equivalence or effectiveness of one type of intervention over the other.

Keywords

Gastroesophageal Reflux Disease; Robinia Pseudacacia; Individualized Homoeopathy; Evidence Synthesis; PRISMA; Risk of Bias.

1. Introduction

Gastroesophageal Reflux Disease is a widespread condition characterized by troublesome symptoms that result from refluxed gastric contents. Heartburn andRegurgitation are hallmark symptoms, although the symptom profiles can be shared with functional syndromes and other causes of esophageal discomfort. Diagnosis can involve assessing symptoms, performing endoscopy or ambulatory reflux monitoring if there remains some diagnostic doubt. Lyon

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Consensus 2.0 recommends the demonstration of objective reflux and making the distinction between proven and unproven GERD (Gyawali, et al., 2024).

Based on evidence, the management of the disease can include Weight Modifications, Individualized Diets, and Acid Suppression, among other actions. The Proton Pump Inhibitors are a mainstay medication treatment option; persisters should undergo a reassessment rather than the assumption that the trouble is mediated by the acid. Recent recommendations in Gastroenterology pay attention to shared decision-making and phenotyping of reflux presentations (Katz, et al., 2022)(Yadlapati, Gyawali, Pandolfino, & Participants, 2022). Emotional Stress and Suppressed Emotions have also been proposed as contributors to stress-related and functional complaints, including Gastrointestinal Symptoms; however, such associations should not be treated as causal unless tested in designs that can rule out bias and reverse causation(Lathiya, et al., 2026).Emotional suppression and its effects on health, along with homoeopathic management, have also been studied in the homoeopathic literature (Lathiya & Patel, Original Research Article: Study of "Emotional Suppression" – Its Effects And Homeopathic Management, 2024).

Robinia PseudacaciaRemedy is mentioned in the Homoeopathic literature to be used for Sour Eructation, Acidity, and Burnings. The Remedy-Specific Prescription utilizes this named preparation according to a particular pattern of symptoms. Individualized Homoeopathy, in its turn, chooses remedies for different patients based on the consultation and symptom assessment. In individualized practice, the remedy is chosen from the totality of the patient's symptoms rather than from the disease label alone(Lathiya P. , 2022), and constitutional remedies, with an intercurrent remedy where needed, are prescribed after a detailed history that includes Emotional Factors (Lathia, Patel, Shah, & Gamit, 2025). These approaches differ not only in selecting medicines, scheduling dosing and in the clinical context of the encounter, thus making any indirect comparisons very challenging. Neither a classical indication nor any improvement from a given remedy proves the drug-specific effect.Homoeopathy is also used in community and preventive care, and surveys have looked at public awareness, use and perceived integration with community health services(Lathiya, et al., 2026); these describe how it is used, not whether a particular remedy works. For example, a retrospective single-clinic series of 300 chronic cases, which included 14 patients with GERD, reported significant improvement in 177 cases and moderate improvement in 80 cases after Individualized treatment with counselling(Lathia, Rao, & Modi, 2025)(Lathia, Patel, Shah, & Gamit, 2025). Such reports are uncontrolled and rely on categorical, subjective outcome ratings. They also describe the same cohort, and a Natrum-group subset of it

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was reported separately(Lathia, Shah, & Gavli, Silent suffering of the Natrum personality: A homeopathic insight into unexpressed emotions and unresolved conflicts, 2025), so they should not be counted as independent evidence.

An adequate comparison requires Randomization of patients to Robinia and Individualized treatments, controlling for concurrent traditional treatment, measuring initial severity and adverse events, among other parameters. The current review evaluates the current studies as to whether any of them answers this question, while distinguishing uncontrolled treatment outcomes and externally controlled efficacy evidence.

2. Purpose and Question

The First purpose was to evaluate the evidence comparing Robinia Pseudacacia and Individualized Homoeopathic treatment for GERD. Secondary questions were focused on Severity, Heartburn, Regurgitation, Quality of Life, reporting of adverse events, internal validity and certainty of evidence. This question implies an improvement within different cohorts is not interpreted as superiority of interventions.

3. Materials and Methods

3.1 Design and Scope

This report employs eligibility criteria and PRISMA 2020 framework(Page, et al., 2021) for selecting a non-exhaustive set of relevant sources. It is not claimed to present an exhaustive search of databases and thus lacks downloadable histories of searches, database export records, records of duplicates and independent dual-screening data. As such, Figure 1 below shows this source records actually identified due to the investigator input and source verification. Protocol registration was not planned.

3.2 Identification

Twenty-one articles submitted by the investigator were screened as to the GERD relevance. Six source publications were identified and verified via the publisher or publication websites: Agarwal (2019), Mittal et al. (2016), Dossett et al. (2015), Dighe (2020), Bhople and Gupta (2025), and Gavhane et al. (2025).

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3.3 Eligibility

Original clinical studies evaluating diagnosed/defined adult GERD, Robinia-based remedy-specific or Individualized Homoeopathic therapy and at least one outcome parameter were included for a narrative synthesis. The mixed Gastrointestinal samples could provide results on GERD condition only if separable. The reviews and condition mismatches were excluded from any efficacy synthesis. The Dossett et al.(Dossett, et al., 2015) studied fixed combination remedy Acidil rather than either of the interventions above, hence its Placebo-Controlled Trial was considered indirect evidence only.

3.4 Data Extraction and Appraisal

The study Year, Design, Sample Size, Choice of Therapy, Duration and Quantitative Outcomes were collected from Abstracts and reports on the publisher website. Single group study design was appraised for structural bias and outcome ascertainment. A Retrospective Cohort was also separately marked due to record selection and reporting issues. The Item-Level Assessment using JBI guidelines will require methods description of all sources and a prespecified judgement on them(Barker, et al., 2024). Only the randomized study will use RoB 2 assessment. Missing pair of standard deviations was not imputed.

3.5 Data Synthesis

The descriptive comparison was preferable since the arms, populations, outcome instruments and duration of follow-up varied across studies. No cross-study calculation of indirect effects and overall pool estimate, I^2 and τ^2 are presented. For clarity, the Figure 2 below presents three difference means calculated within the Australian government evidence evaluation of Acidil trial(HTANALYSTS, 2024). However, the figure does not evaluate Robinia against Individualized efficacy. The outcomes in the figure preserve their separate instrument units; no standardization and pooling are possible in the case of the data from small factorial trial. Candidate sources dated 2026 year are outside the pre-specified date period and were not used to evaluate the historical efficacy.

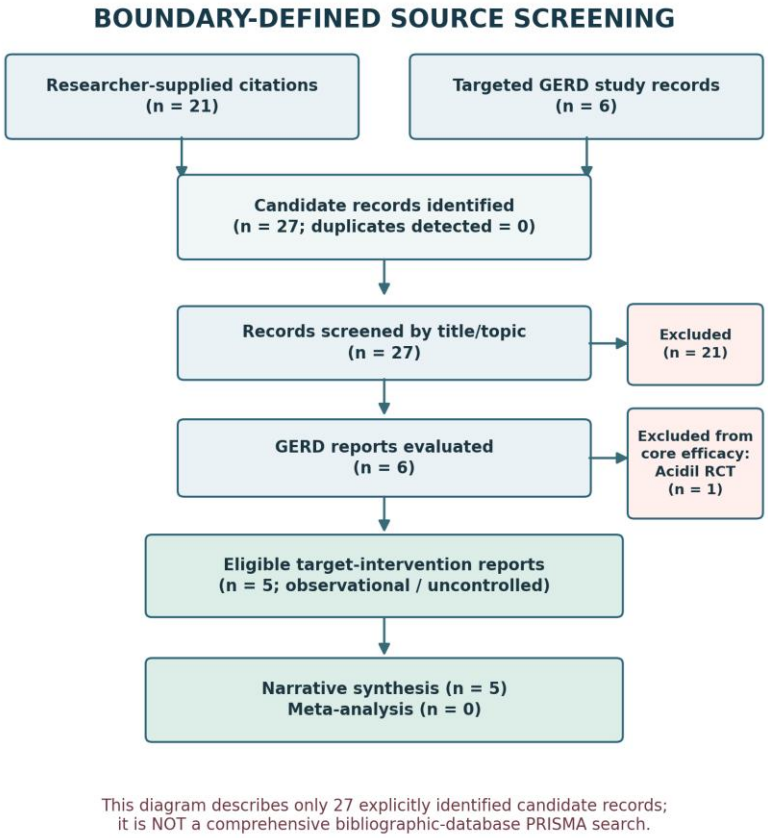
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4. Results

4.1 Selection

From twenty-seven candidates, 21 did not concern the GERD and were excluded during topical screening. Six GERD reports were selected. The only Randomized AcidilStudy did not evaluate the interventions of interest, thus five clinical reports are available for the target interventions synthesis: one Robinia-specific Cohort, three Prospective Individualized/Constitutional Cohorts and one Retrospective Multiple-Remedy Series. Thus, five studies contribute to a narrative synthesis, none – to a head-to-head meta-analysis. These numbers reflect curation of sources, not any claim of database retrieval.

Figure 1. PRISMA-style flow of 27 explicitly identified candidate sources; not a comprehensive database retrieval history.



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4.2 Robinia-Related Results

Agarwal (2019)(Agarwal, 2019) followed 30 GERD patients administered Robinia Pseudacacia 6C in repeat dosages over six months. One person was categorized as having been cured, 26 experienced good improvement and three patients did not respond. Paired test of GerdQ was given as p <001. Without any untreated or control group, such classifications cannot distinguish between Natural Course of Disease, Co-Interventional Influences, Placebo Effect and Homeopathic Medication. The percentages reflect the classification made among the initial group of participants.

4.3 Treatment as per Individual Needs

In their study, Mittal et al. (2016) (Mittal, et al., 2016)included 78 participants, 34 with diagnosed Nonerosive Reflux and prescribed treatment for eight weeks in accordance with patients' symptomatology. Average GERD score fell from 8.79 ± 2.7 to 0.76 ± 1.8, while average Heartburn score dropped from 47.47 ± 19.6 to 5.06 ± 11.8; in both cases p was presented as equal to .001. There were also changes to Psychological, Social and Environmental Quality of Life areas. Without any concurrent control it is not possible to attribute causality, while provided marginal standard deviations do not allow for calculating a confidence interval for change.

Table 1. Summary of eligible GERD clinical studies

Study	n	Design And Intervention	Duration	Verified Result
Agarwal 2019(Agarwal, 2019)	30	Prospective; Robinia 6C	6 months	GerdQ: 1 cured, 26 improved, 3 unchanged; p < .001
Mittal 2016(Mittal, et al., 2016)	34	Prospective; individualized	8 weeks	GERD mean 8.79 to 0.76; paired p = .001
Dighe 2020(Dighe, 2020)	40 GERD	Retrospective; multiple remedies	Not confirmed	70% subjectively improved in GERD subgroup
Bhople 2025(Bhople & Gupta, 2025)	40	Prospective; individualized	Not confirmed	GerdQ pre–post p < .05
Gavhane 2025(Gavhane, et al., 2025)	30	Uncontrolled; constitutional	6 months	FSSG improved; comparative effect unavailable

Dighe (2020)(Dighe, 2020) retrospectively analyzed 100 Gastrointestinal patients, including 40 patients with GERD; subjective improvement was mentioned for 70% of patients in the GERD subgroup. In this study 52.5% of GERD cases occurred with Homeopathic prescription of ArsenicumAlbum, showing treatment variability. Bhople and Gupta (2025)(Bhople & Gupta,

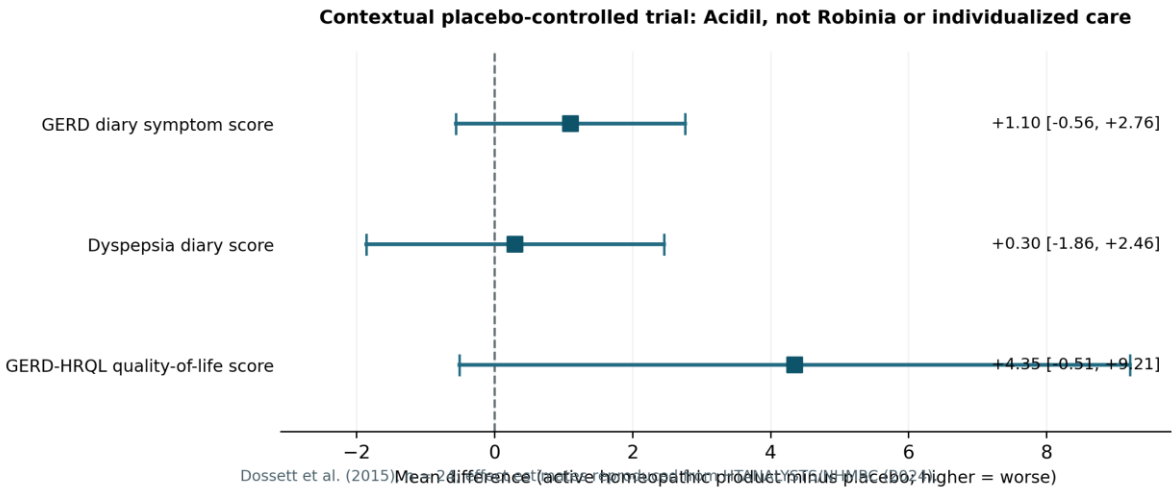
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2025) studied 40 adult patients, selected Individual remedies and applied GerdQ assessment and found a statistically significant improvement in symptoms ($p < .05$). Gavhane et al. (2025)(Gavhane, et al., 2025) studied 30 patients treated using constitutional approach on the basis of FSSG scale over six months; no control was used, while the improvement was mentioned. Definition of outcomes was inconsistent enough to justify pooling.

4.4 Indirect RCT

In their study published in 2015, Dossett et al.(Dossett, et al., 2015) randomized 24 participants in a two-by-two factorial design using Acidil and Placebos as variables. No statistically significant effect of Acidil over Placebo on severity of GERD symptoms was reported ($p = .41$). An evaluation performed in Australia produced a result that the mean difference in GERD symptom score between groups was equal to +1.10 (95% CI −0.56 to +2.76; higher values are worse); Dyspepsia score is +0.30 (−1.86 to +2.46) and GERD-HRQL score is +4.35 (−0.51 to +9.21) (HTANALYSTS, 2024). These figures cover zero. The report assigned very low certainty rating.

Figure 2. Forest-style display of three outcomes from one AcidilPlacebo-Controlled GERD trial; no pooled estimate and no direct comparison with Robinia or Individualized care. Higher scores indicate worse outcomes.



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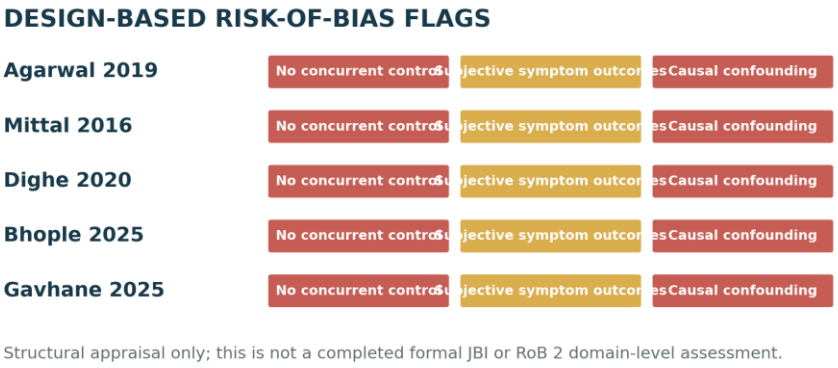
4.5 Potential for Bias and Certainty

All target-intervention studies were unable to provide an equivalent comparison group. Thus, it is not possible to dissociate confounding, regression to the mean, spontaneous fluctuations, and consultation effects from treatment effects. Almost all evidence comes from subjective reports or retrospective evaluations. No presence of a control target-intervention study makes it impossible to generate a proper GRADE rating on relative effectiveness, whose certainty can be defined as unestablished. Figure 3 highlights important design limitations without assigning an unjustified domain rating.

Table 2. Comparative outcome reporting and interpretive limitations.

Study	Outcome	n	Control Group	Interpretive Limitation
Robinia 2019	GerdQ; clinical classification	30	No	No randomized comparator
Individualized 2016	GerdQ; VAS; WHO-QOL	34	No	Paired standard deviation unavailable
Mixed remedies 2020	Subjective improvement	40 GERD	No	Retrospective, heterogeneous therapies
Individualized 2025	GerdQ	40	No	Uncontrolled; reporting gaps
Constitutional 2025	FSSG	30	No	Uncontrolled; scale differs

Figure 3. Design-level methodological vulnerabilities of the five included target-intervention reports; labels are structural flags rather than a formal risk-of-bias instrument score.



5. Discussion

Key finding: Discrepancy between observation of improvement and evidence of effectiveness.

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One group of Robinia received the medicine and was reported to improve in one pilot study; also lower scores were seen in the other, Individualized cohorts. However, these groups were enrolled at different places, followed over varied durations, and treated with regard to different selection criteria. Outcome magnitudes are not exchangeable. The comparison of response rates would constitute the ecological bias because of differences between study-level baselines that could account for the advantage.

Significant within-person symptom change in the Mittal trial is fascinating, however, it should be evaluated against the background. Symptoms vary, selection of eligible patients usually happens when they are under distress, and following up coincides with natural return to their normal state. Frequent patient inclusion increases the risk of regression to the mean. Patient expectations, Diet information, Rescue drugs, and contacts with physicians can influence self-reported Heartburn. Significantly high paired p value characterizes consistency with the model with 0 average pre- and post-change, and does not estimate the effectiveness over placebo and prove superior treatment.

27 beneficial clinical classification of the outcome in the Robinia study among 30 participants might appear more powerful than retrospectively reported 70% improvement in Dighe's GERD subgroup. Nevertheless, latter was a mixed medication use with different response categories and retrospective identification; hence, numeric difference is not sufficient for a direct therapeutic hierarchy. Even within single cohort, categories such as cure, good improvement or moderate improvement should have certain cut-offs, blinded assessment, and pre-specified handling of missing follow-ups before comparisons.

2025 papers increase the number of condition-related descriptive publications, but do not resolve decisive limitation. In the Bhople–Gupta trial, Individualized prescription relied on Totality of Symptoms and GerdQ was statistically significantly changed; without randomized control group, contribution of treatment is unclear. The Gavhane series employed FSSG in place of GerdQ and its constitutional prescribing approach results in increased heterogeneity of intervention. Instruments measure overlapping, but not identical variables, and effect conversion without Individual patient data is complicated.

The Acidil trial offers a great contrast. Its fixed combination drug is neither Robinia alone nor an Individualized Remedy; hence, the conclusion about it is not transferable to the question. Nevertheless, it failed to show benefit over placebo, while duration and style of consultation had

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influence on the outcome. Governmental synthesis found wide confidence intervals containing both benefit and harms and regarded the evidence as very uncertain (HTANALYSTS, 2024). These findings illustrate importance of balancing effect of consultations between arms in a future Homoeopathic trial.

Clinical significance of results would imply the distinction of symptomatic relief from clinically verified Reflux Disease. Decrease in questionnaire score can represent relief of Functional Heartburn, Reflux Hypersensitivity, Intermittent Acid Exposure, and Behavioral Change. Lyon Consensus 2.0 recommends and guidance suggest objective testing if further clarification of diagnosis is necessary(Gyawali, et al., 2024). Ideally, research population should be clearly defined, with stratification by proven Erosive Disease, Nonerosive Reflux Disease, and Functional Symptoms' presence instead of pooling all Upper Abdominal Burning under GERD.

Superiority Trial could be designed with Centralized Randomization, Equal Visit Schedule, Blinded Outcome Assessor, And Standardized Concomitant GERD Medication. Comparison of Individualized care with fixed Robinia prescribing strategy would raise issues with blinding due to the fact that Individualized group can get additional medicines and spend time on consultations; these should be predefined before enrollment. Three-arm Trial employing a Placebo or standard-of-care comparator could discriminate different approaches from effects of nonspecific patient management. Outcomes should include GERD-HRQL or GerdQChange, Medication Usage, and Prespecified Minimal Difference, with adverse event monitoring.

Patient safety and reporting-ness issues should be considered. The reviews, based on small observational publications, cannot assume that the absence of adverse events means established safety. Ongoing Reflux with Progressive Dysphagia, Gastrointestinal Bleeding, Weight Loss, And Anemia require prompt medical attention. Since the guideline identifies the acid-suppressing treatments for selected GERD phenotypes, any unproved adjuncts are not supposed to replace diagnostic procedures and evidence-based management (Katz, et al., 2022).

Interpretation should also take into account the clinical path of treatment allocation. The threshold for symptomatic GerdQ score can be only recruitment criterion, but not a confirmation of Pathological Acid Exposure. Future trials should include details about diagnostic testing, Helicobacter pylori if applicable, Hiatus Hernia, Body Mass Index, Smoking Status, Previous PPI Exposure, and Treatment Failures. Patients should be advised about meals, lying positions and

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rescue therapy across trial arms. Without those measures, reported improvement could result from the change in baseline exposures instead of particular treatment approach.

Numerical Synthesis should require publication of participant numbers at follow-up, standard deviation of paired change in scores and estimates of effects on the scale. Publication of only baseline and final standard deviations does not imply the covariance of repeatedly measured scores, and paired confidence interval cannot be calculated correctly. Binary categories of response require cut-offs set beforehand. Domains, symptoms and time points testing should be reported for multiple testing to be accounted for.

6. Clinical Implications and Limitations

Publications might contribute to formulation of feasibility issues on Recruiting, Scoring, And Follow-up, but insufficient to select Robinia treatment over Individualized Homoeopathic prescribing in routine GERD management. Evidence program should register outcomes, publish de-identified aggregated dataset, specify treatment strategy and changes in remedy and dose, as well as collect information about adverse events related to reflux. Implementation assessment should separate time spent with clinicians and effect due to prescribed treatment.

Limitations of this manuscript include defined candidate-source frame, lack of reproducible search across all databases, variability in access to the complete methodology of included studies and absence of independent dual data extraction. Thus, PRISMA-style figure presented in this manuscript cannot be interpreted as a result of comprehensive search. Some outcomes appeared in abstracts, missing variances have not been imputed, and no clinical findings were invented. Later publications could have escaped detection. A properly registered systematic review will repeat search and risk of bias assessment prior to journal submission.

7. Conclusion

Identified Five Uncontrolled Trials of GERD report outcomes after Robinia-specific or Individualized Homoeopathic Prescription, but none of them compares the approaches in a randomized manner. Within-group improvement is insufficient to demonstrate efficacy, equivalence or superiority. The separate Acidil placebo trial offers only very low-certainty

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evidence, and cannot be transferred to one of two target interventions. Further rigorous comparative studies are required; until this moment, clinical decisions should be evidence-based.

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