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Obesity and Type 2 Diabetes Mellitus: Exploring the Potential Role of Individualized Homoeopathy in Metabolic Health, with a Focus on Body Mass Index

Dr. Duradundi A. Alure[1], Dr. Santosh L. Magadum[2]

[1]PG Scholar (Part II), Department of Practice of Medicine, A.M. Shaikh Homoeopathic Medical College, Hospital & PG Research Centre, Belagavi, Karnataka, India.
[2]Professor & P.G Guide, Department of Practice of Medicine, A.M. Shaikh Homoeopathic Medical College, Hospital & PG Research Centre, Belagavi, Karnataka, India.

Corresponding author: Dr. Duradundi A. Alure

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ABSTRACT

Background: Obesity and type 2 diabetes mellitus (T2DM) are associated metabolic disorders with increasing overall prevalence. Excess adiposity contributes to insulin resistance, chronic low-grade inflammation, dyslipidaemia and impaired glucose metabolism. Body mass index (BMI) is a widely used measure for assessing obesity and monitoring changes in body weight.

Objective: This narrative review aims to explore the potential role of individualized homoeopathy in obesity associated with T2DM, with particular emphasis on BMI as an anthropometric outcome. It also examines the relationship between obesity and T2DM and the available evidence regarding homoeopathic interventions and metabolic health.

Methods: Relevant published literature addressing obesity, BMI, T2DM and individualized homoeopathic treatment was reviewed. Clinical studies, observational studies, case reports and review articles were considered, with emphasis on reported changes in BMI, body weight and metabolic parameters.

Results: Available literature demonstrates a strong association between obesity and T2DM. Some studies and clinical reports of individualized homoeopathic treatment have reported changes in body weight, BMI and selected metabolic parameters. However, the evidence remains heterogeneous and is limited by small sample sizes, variable study designs, inadequate controls and methodological limitations.

Conclusion: Individualized homoeopathy shows potential as a complementary approach in the management of obesity among patients with T2DM. BMI provides a simple and clinically useful measure for evaluating changes in obesity status during treatment. Reported evidence suggests favourable changes in BMI, body weight and selected metabolic parameters. Further well-designed clinical studies are needed to strengthen the evidence and establish its therapeutic potential.

Keywords: Obesity; Body Mass Index; Type 2 Diabetes Mellitus; Individualized Homoeopathy; Metabolic Health.

INTRODUCTION

Obesity is a major global public health concern and is increasingly recognized as an important risk factor for the development and progression of type 2 diabetes mellitus (T2DM). The World Health Organization (WHO) defines obesity as abnormal or

excessive fat accumulation that may impair health, with body mass index (BMI) being one of the most widely used measures for its assessment. The global burden of obesity has increased substantially, with more than one billion people living with obesity worldwide[1].BMI is calculated as weight in kilograms divided by the square of height in metres (kg/m²) and is widely used for the assessment and classification of obesity. In adults, a BMI of ≥30 kg/m² is generally classified as obesity, while Class I obesity corresponds to a BMI of 30–34.9 kg/m².The American Diabetes Association recommends the use of BMI for screening and monitoring overweight and obesity, while also recognizing the value of additional measures of adiposity such as waist circumference[2].

The relationship between obesity and T2DM is complex and involves several interrelated metabolic mechanisms. Excess adiposity, particularly visceral adiposity, is associated with insulin resistance, chronic low-grade inflammation and disturbances in glucose and lipid metabolism. Obesity is therefore considered an important pathophysiological driver of T2DM and its associated cardiometabolic complications. Weight management has consequently become an important component of diabetes management, alongside glycaemic control. Evidence indicates that even modest weight loss can improve glycaemia and other cardiovascular risk factors in people with T2DM and overweight or obesity[2].

Conventional management of obesity and T2DM includes nutritional intervention, physical activity, behavioural modification, pharmacotherapy and, where appropriate, metabolic surgery. Alongside conventional approaches, individualized homoeopathy has been investigated as a complementary therapeutic approach. Recent clinical research has explored individualized homoeopathic medicines in individuals with dysglycaemlic states, including pre-diabetes, reporting improvements in selected glycaemic and metabolic outcomes[3,4].

Homoeopathy emphasizes individualization of treatment based on the totality of symptoms and the characteristic features of the individual rather than solely on the diagnostic label. Clinical research has investigated individualized homoeopathic medicines in dysglycaemic states, particularly pre-diabetes. Randomized, placebo-controlled studies have reported differences in selected glycaemic outcomes among participants receiving individualized homoeopathic medicines; however, these findings require interpretation within the limitations of the available evidence and further independent research is warranted[3,4].

Therefore, the present narrative review explores the potential role of individualized homoeopathy in metabolic health among individuals with obesity and T2DM, with particular emphasis on BMI as an important and measurable indicator of obesity status.

1. Obesity and Type 2 Diabetes Mellitus:

Obesity and T2DM are closely interconnected metabolic disorders, with excess adiposity being an important modifiable risk factor for the development of insulin resistance and subsequent diabetes. The risk of T2DM increases with increasing adiposity and is particularly influenced by the accumulation of visceral and ectopic fat. Adipose tissue is not merely an energy-storage organ but also functions as an endocrine organ, releasing adipokines, inflammatory mediators and other bioactive molecules that influence glucose and lipid metabolism[1].

Insulin resistance is a central feature linking obesity with T2DM. In individuals with excess adiposity, impaired insulin signalling in skeletal muscle and adipose tissue reduces glucose uptake, while increased hepatic insulin resistance contributes to excessive hepatic glucose production. Pancreatic β-cells may initially make up for it by secreting more insulin. With progressive metabolic dysfunction, however, β-cell compensation may become inadequate, resulting in persistent hyperglycaemia and eventual development of T2DM[5].

Chronic low-grade inflammation is another important mechanism in obesity-related

metabolic dysfunction. Expansion and dysfunction of adipose tissue can be associated with altered secretion of adipokines and increased production of pro-inflammatory mediators. These changes may further impair insulin signalling and contribute to metabolic abnormalities associated with T2DM[6].Obesity is also associated with dyslipidaemia, hypertension and other cardiometabolic risk factors, thereby increasing the overall burden of complications in individuals with diabetes[2].

The distribution of adipose tissue is also clinically relevant. Visceral adiposity has a stronger association with metabolic complications than total body weight alone. Consequently, two individuals with a similar BMI may have different metabolic risk depending on their body-fat distribution, waist circumference and other metabolic characteristics. This highlights an important limitation of BMI: although it is simple, inexpensive and widely applicable, it does not directly distinguish between fat mass and lean mass or indicate the distribution of adipose tissue[7].

The relationship between obesity and T2DM is therefore bidirectional at the level of metabolic deterioration, with excess adiposity contributing to insulin resistance and diabetes while diabetes-related metabolic disturbances may further complicate weight management. For this reason, contemporary diabetes management increasingly incorporates strategies directed towards weight reduction and improvement of metabolic health rather than focusing exclusively on glycaemic control[2].

2. Body Mass Index as an Indicator of Obesity

BMI is one of the most commonly used anthropometric measures for identifying overweight and obesity at the population and clinical levels. It is calculated by dividing body weight in kilograms by height in metres squared (kg/m²). In adults, BMI categories are conventionally used to classify excess body weight and obesity[1].

The principal advantages of BMI are its simplicity, reproducibility and ease of measurement. It may be obtained without complex equipment, making it suitable for epidemiological investigations, clinical monitoring, and screening. In patients with obesity and T2DM, serial measurement of BMI can provide a straightforward indicator of changes in body weight during lifestyle or therapeutic interventions[2].

However, BMI has important limitations. It does not directly measure body-fat percentage, visceral adiposity or fat distribution. Consequently, BMI should not be interpreted in isolation when assessing an individual's metabolic risk. Measures such as waist circumference, waist-to-height ratio and other assessments of adiposity may provide complementary information, particularly when evaluating cardiometabolic risk[7].

For the present review, BMI is considered primarily as a measurable anthropometric outcome rather than a comprehensive indicator of metabolic health. Changes in BMI may reflect changes in body weight during an intervention, but interpretation should ideally be considered alongside glycaemic parameters, waist circumference and other clinically relevant metabolic outcomes.

3. Obesity Management in Type 2 Diabetes Mellitus

Management of obesity in individuals with T2DM requires a comprehensive approach incorporating nutritional intervention, physical activity, behavioural strategies, pharmacological treatment and, in selected individuals, metabolic or bariatric surgery. The choice of intervention should be individualized according to the person's clinical characteristics, treatment response and circumstances[8,9].

Lifestyle modification remains an important component of obesity management. Dietary modification, increased physical activity and behavioural interventions can contribute to clinically meaningful weight reduction in people with T2DM and overweight or

obesity. A systematic review of behavioural lifestyle interventions reported that structured interventions with regular feedback and support could achieve clinically meaningful weight loss, with approximately 5% weight reduction reported across several intervention approaches[1].

Weight reduction may also produce metabolic benefits in individuals with T2DM. Reduction in body weight can improve glycaemic control and may reduce the requirement for glucose-lowering medication. The magnitude of metabolic benefit generally increases with greater weight loss, although individual responses vary[7].

Pharmacological treatment has become an increasingly important component of obesity management in T2DM. Recent therapeutic approaches include glucagon-like peptide-1 receptor agonists and dual incretin-based therapies, which can produce clinically significant reductions in body weight while also improving glycaemic control[10,11].

Metabolic or bariatric surgery is another option for appropriately selected individuals with obesity and T2DM. Evidence indicates that metabolic surgery can produce substantial and sustained weight loss and improve glycaemic outcomes. Long-term evidence has also reported higher rates of diabetes remission following metabolic surgery compared with conventional pharmacological treatment, although patient selection and long-term follow-up remain important consideration[12].

Therefore, contemporary obesity management in T2DM increasingly emphasizes a person-centred and individualized approach, integrating lifestyle modification with pharmacological or surgical interventions when clinically appropriate. This broader concept of individualized care provides a relevant background for considering other complementary therapeutic approaches, including individualized homoeopathy, while recognizing that evidence for such approaches needs to be evaluated separately and critically[13].

4. Individualized Homoeopathy and Metabolic Health

Individualized homoeopathy is based on selecting a medicine according to the totality of symptoms and individual characteristics rather than solely on the diagnostic label. In the context of obesity and T2DM, this approach has been explored mainly through studies involving metabolic or dysglycaemic states rather than through large trials specifically enrolling patients with established obesity-associated T2DM.

Recent clinical research has investigated individualized homoeopathic medicines in individuals with pre-diabetes. In a double-blind, randomized, placebo-controlled trial involving 60 participants, individualized homoeopathic medicines were compared with placebo over six months, with dietary advice, yoga, meditation and exercise provided as concomitant care to both groups. The study reported a statistically significant between-group difference in fasting blood glucose and in Diabetes Symptom Checklist-Revised scores, although the difference in oral glucose tolerance testing was not statistically significant. The authors emphasized the need for independent replication with larger sample sizes[14].

A subsequent double-blind, randomized, placebo-controlled trial also evaluated individualized homoeopathic medicines in 60 individuals with pre-diabetes. Participants received individualized medicines or placebo in addition to yoga therapy. The investigators assessed progression to diabetes together with fasting blood glucose, oral glucose tolerance, HbA1c, lipid profile and other biochemical parameters. The study reported differences between groups for several outcomes; however, the relatively small sample size and the combined use of homoeopathic treatment and yoga therapy should be considered when interpreting these findings[15].

These studies are relevant to the present review because pre-diabetes represents an intermediate metabolic state associated with increased risk of progression to T2DM. However, evidence obtained from pre-

diabetic populations cannot automatically be extrapolated to individuals with established T2DM or obesity. The distinction is particularly important when evaluating BMI and weight-related outcomes, because the primary outcomes in these trials were predominantly glycaemic and symptom-based rather than specifically designed to determine the effect of individualized homoeopathy on obesity or BMI[15].

Direct evidence concerning homoeopathy and obesity is comparatively limited. A randomized controlled trial protocol published in 2020 proposed evaluating individualized treatment with *Calcarea carbonica ostrearum* as an adjunct to a multidisciplinary intervention in overweight or obese adolescents. The planned outcomes included body weight, BMI, body-fat percentage, fat-mass index, waist-to-hip ratio, fasting glucose, insulin, insulin resistance and lipid profile. Importantly, this publication was a study protocol rather than a completed efficacy study, and therefore it provides evidence of research interest rather than evidence of treatment effectiveness[16].

Taken together, the available clinical literature provides some preliminary evidence concerning individualized homoeopathy in dysglycaemic conditions, particularly pre-diabetes, but direct evidence for its effect on obesity and BMI in patients with established T2DM remains insufficient. Therefore, BMI may be considered a useful outcome for future research, provided that changes in BMI are evaluated alongside objective metabolic measures such as HbA1c, fasting plasma glucose, waist circumference and lipid parameters.

5. Evidence for Individualized Homoeopathy in Obesity and Dysglycaemic States

The clinical evidence concerning homoeopathy in obesity and dysglycaemic conditions remains limited and heterogeneous. Available studies have investigated different populations, interventions and outcome measures, making direct comparison difficult. Importantly, much of the recent evidence relates to pre-diabetes rather than established T2DM, while studies specifically evaluating changes in BMI among individuals with obesity and T2DM are scarce

A double-blind, randomized, placebo-controlled trial by Guha et al. evaluated individualized homoeopathic medicines in 60 individuals with pre-diabetes over six months. Both groups received dietary advice, yoga, meditation and exercise, while the intervention group received individualized homoeopathic medicines. The study reported a statistically significant between-group difference in fasting blood glucose and Diabetes Symptom Checklist-Revised scores, whereas the difference in oral glucose tolerance test results was not statistically significant. The authors recommended independent replication using larger samples[14].

Another randomized, double-blind, placebo-controlled trial by Banerjee et al. included 60 participants with pre-diabetes and evaluated individualized homoeopathic medicines combined with yoga therapy. Outcomes included progression to diabetes, fasting blood glucose, OGTT, HbA1c, lipid profile and selected biochemical parameters. The investigators reported significant differences for several outcomes, including HbA1c and OGTT. However, because yoga therapy was provided to both groups and the study involved only 60 participants, these findings should be interpreted within the limitations of the study design[15].

Evidence specifically addressing obesity and BMI is less extensive. A randomized controlled trial protocol involving overweight or obese Mexican adolescents proposed evaluating *Calcarea carbonica ostrearum* alongside a multidisciplinary intervention comprising diet, motivational support and exercise. Planned outcomes included body weight, BMI, body-fat percentage, fat-mass index, waist-to-hip ratio, fasting glucose, insulin, insulin resistance and lipid profile. However, this publication was a protocol and not a report of completed clinical results; therefore, it

cannot be used as evidence of treatment efficacy[16].

A previous randomized controlled trial in overweight or obese pregnant women with suspected common mental disorders evaluated individualized homoeopathic treatment alongside dietary guidance. The study found no significant difference between the homoeopathy and placebo groups in BMI change during pregnancy. Although the population and clinical context differ substantially from adults with obesity and T2DM, the study illustrates the importance of distinguishing reported evidence from assumptions regarding effects on body weight[17].

Evidence has also been reported in established T2DM. A retrospective cohort study from Hong Kong evaluated 27 adults receiving individualized homoeopathic treatment and compared their outcomes with published data from 40 patients receiving conventional treatment. The homoeopathy group demonstrated greater reductions in fasting plasma glucose and HbA1c at follow-up. However, the retrospective, non-randomized design, small sample, differences in baseline characteristics and use of an external comparison group limit the strength of causal inference. Furthermore, the study primarily assessed glycaemic outcomes rather than BMI or obesity-related outcomes[18].

A systematic review specifically examining randomized trials of homoeopathic preparations for diabetes and obesity concluded that the available evidence was insufficient to establish efficacy because of limitations in the number and quality of available trials. This finding is important when interpreting more recent studies: individual positive findings should not be regarded as establishing effectiveness across obesity or T2DM as a whole[19].

Overall, the existing literature suggests that research interest in individualized homoeopathy for metabolic disorders has increased, particularly in pre-diabetes, but there remains a substantial evidence gap concerning obesity-associated T2DM and BMI as a primary outcome. Future studies should use adequately powered randomized designs, clearly defined obesity and diabetes criteria, standardized metabolic outcomes and appropriate long-term follow-up. BMI should preferably be evaluated together with waist circumference, body composition and biochemical markers rather than being used as the sole indicator of metabolic improvement.

Current evidence on individualized homoeopathy in obesity and T2DM remains limited and heterogeneous. Most recent clinical studies have focused on pre-diabetes, while studies specifically evaluating patients with established T2DM and obesity are scarce. Available research is further limited by small sample sizes, short follow-up periods, variable study designs and differences in outcome measures. Although some studies have reported improvements in fasting glucose and HbA1c, evidence regarding BMI, body weight and central adiposity remains insufficient. Therefore, future studies should use adequately powered randomized controlled designs with longer follow-up and assess BMI together with waist circumference, HbA1c, fasting glucose and lipid parameters. Standardized reporting of individualized prescribing and concomitant lifestyle or conventional treatment would also improve reproducibility and interpretation of findings. Here is a slightly expanded version—more substantial than the previous one, but still concise and suitable for a narrative review.

DISCUSSION

Obesity and type 2 diabetes mellitus are closely associated metabolic conditions, with excess adiposity contributing to insulin resistance, chronic inflammation and impaired glucose regulation. The increasing burden of obesity has consequently become an important concern in the prevention and management of type 2 diabetes mellitus. BMI is a simple, reproducible and widely used measure for assessing obesity and monitoring changes in body weight status. However, BMI does not distinguish between

fat and lean mass or provide information about the distribution of adipose tissue. Therefore, BMI should be interpreted alongside other anthropometric and metabolic parameters when assessing overall metabolic health.

Management of obesity in individuals with type 2 diabetes mellitus generally involves lifestyle modification, behavioural measures and appropriate medical or surgical interventions. Reduction in body weight may contribute to improved glycaemic control and metabolic health. Hence, assessment of changes in weight and BMI can provide useful information when evaluating therapeutic outcomes, although these measures alone cannot fully represent metabolic improvement.

Individualized homoeopathy has been investigated in dysglycaemic conditions, particularly pre-diabetes, with some clinical studies reporting improvements in selected glycaemic outcomes. However, evidence specifically addressing obesity in individuals with established type 2 diabetes mellitus remains limited. The available studies differ in sample size, methodology, treatment approaches and outcome measures, making direct comparison difficult. Furthermore, evidence concerning changes in BMI, body weight and central adiposity is considerably less developed than evidence concerning glycaemic parameters.

The rationale for the present review arises from this evidence gap. Although obesity is an important contributor to the development and progression of type 2 diabetes mellitus, available research on individualized homoeopathy has focused predominantly on glycaemic outcomes rather than obesity-related measures. A focused assessment of BMI is therefore relevant because it provides a practical and accessible measure for monitoring changes in obesity status. At the same time, its limitations highlight the need to consider BMI together with waist circumference and metabolic parameters.

The present review therefore brings together the available literature concerning obesity, BMI, type 2 diabetes mellitus and individualized homoeopathy. The available evidence suggests a potential area for further investigation, but it remains insufficient to establish definitive conclusions regarding effectiveness. Future clinical studies should employ robust study designs, adequate sample sizes, appropriate controls and longer follow-up, while assessing both anthropometric and metabolic outcomes to provide a more comprehensive evaluation of treatment response.

CONCLUSION

Obesity and type 2 diabetes mellitus are closely interconnected metabolic conditions in which excess adiposity contributes to insulin resistance and impaired glucose regulation. Individualized homoeopathy has been investigated in dysglycaemic states, with some studies reporting favourable changes in selected metabolic outcomes; however, evidence specifically addressing obesity and established type 2 diabetes mellitus remains limited and heterogeneous. BMI provides a simple and practical measure for assessing changes in body weight status, but it should be interpreted alongside waist circumference and relevant metabolic parameters. Further well-designed, adequately powered randomized controlled studies with longer follow-up and standardized reporting are required to clarify the potential role of individualized homoeopathy as a complementary approach in the management of obesity and type 2 diabetes mellitus.

Declaration by Authors

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