

Review Article

HOMOEOPATHIC THERAPEUTICS IN MIGRAINE: A COMPREHENSIVE REVIEW

Alpana Choudhary¹, Pallavi Gupta²

¹Professor & Head, Department of Homoeopathic Repertory and Case Taking, State National Homoeopathic Medical College and Hospital, Lucknow, Uttar Pradesh, India.

²M.D. Scholar, Department of Homoeopathic Repertory and Case Taking, State National Homoeopathic Medical College and Hospital, Lucknow, Uttar Pradesh, India.

ABSTRACT

Background: Migraine is a common neurological disorder characterized by recurrent episodes of headache associated with symptoms such as nausea, vomiting, photophobia, and phonophobia. It significantly affects the quality of life and functional capacity of affected individuals. Despite advancements in conventional management, including triptans, gepants, CGRP monoclonal antibodies, and behavioral interventions, many patients continue to experience incomplete relief, relapse, medication-overuse headache, or unacceptable side effects. These limitations have stimulated growing interest in complementary and holistic frameworks such as Homoeopathy, which aim to address patient individuality and symptom patterns in a more integrative manner.

Evidence: Available literature suggests that individualized homoeopathic treatment may help reduce the frequency, intensity, and recurrence of migraine attacks while improving overall well-being and quality of life. However, further high-quality clinical studies are required to strengthen the evidence base for its efficacy.

Scope: This review provides an overview of the epidemiology, pathophysiology, clinical features, diagnosis, and management of migraine, with particular emphasis on homoeopathic therapeutics.

Keywords: Migraine, Homoeopathy, Headache, Individualized Treatment, Complementary Medicine, Therapeutics

www.njmrys.com | eISSN: 2395-2911 | Date of Received: -14-8-2026 | Date of Acceptance: 24-09-2026 | Date of Publication: 04-10-2026

INTRODUCTION

Migraine is a primary episodic headache disorder marked by recurring attacks of moderate-to-severe head pain, which are often unilateral and may be accompanied by nausea, vomiting, and increased sensitivity to light and sound.[4] It involves a combination of neurological, gastrointestinal, and autonomic symptoms. Many notable and creative individuals have been known to experience migraines. Diagnosis is made on the basis of the patient's description of headache patterns and related symptoms, as physical, neurological, and laboratory examinations are typically normal and mainly help rule out other serious causes of headache.[5]

EPIDEMIOLOGY

More than 20% of the global population is reported to experience migraine,[6] making it one of the most common causes of headache. Women are affected more frequently than men, with an estimated prevalence of about 15% in women and 6% in men.[7] The prevalence of migraine without aura is around 2.35%, while migraine with aura occurs in about 0.62% of individuals. Migraine without aura affects both genders equally, whereas migraine with aura is more commonly observed among women.[8]

PATHOPHYSIOLOGY

Multiple mechanisms are believed to be involved in the pathophysiology of migraine.

The Vascular Theory

According to the older vascular theory of migraine, headache is produced by vasodilation and aura by vasoconstriction; however, this theory is no longer considered viable.[4]

The Cortical Spreading Depression Theory

The theory of cortical spreading depression was described in detail by A.A.P. Leão. Neuronal and glial depolarization spreading across the cerebral cortex is thought to cause the aura of migraine. This activates the trigeminal afferents, which cause inflammatory changes in the meninges, leading to pain.[9]

The Neurovascular (Trigeminal) Theory

Activation of the trigeminovascular system is also believed to be involved in the pathophysiology of migraine. The trigeminovascular system consists of sensory neurons originating from the trigeminal ganglion and upper cervical dorsal roots; these neurons project to innervate large cerebral vessels, the dura mater, and dural vessels. The convergence of these projections at the trigeminal nucleus caudalis explains the distribution of migraine pain, which involves the anterior and posterior regions of the head and the upper neck. Trigeminal ganglion stimulation leads to the release of vasoactive neuropeptides such as substance P, neurokinin A, and calcitonin gene-related peptide (CGRP), which in turn lead to neurogenic inflammation.[9]

The Integrated Theory

This theory attempts to combine and consolidate the various theories of migraine pathogenesis. According to it, "triggers" of migraine, such as stress, noise, certain foods, dilatation of internal or external carotid arteries, or other factors, initially activate certain brainstem centers, such as the locus ceruleus and the dorsal raphe nucleus. Activation of the locus ceruleus elevates epinephrine levels, and activation of the dorsal raphe nucleus elevates serotonin; this results in cerebral vasoconstriction and a localized decrease in cerebral blood flow. The decrease in cerebral blood flow is then thought to trigger cortical spreading depression, which in turn stimulates

Correspondence: Dr. Pallavi Gupta, M.D. Scholar, Department of Homoeopathic Repertory and Case Taking, State National Homoeopathic Medical College and Hospital, Lucknow, Uttar Pradesh, India. Email id: pallavi.gupta1114@gmail.com

trigeminal nerve fibers, eliciting neurogenic inflammation, vasodilatation, and headache pain.[10]

MAJOR TYPES OF MIGRAINE

Migraine exists in several forms, and although they share certain core characteristics, each individual experiences them differently. Among the various forms, the two most common are **migraine with aura** (previously called *classic migraine*) and **migraine without aura** (previously known as *common migraine*). The defining feature that distinguishes the classic form is the presence of visual or neurological disturbances occurring roughly 30 minutes before the onset of the headache.[11]

- **Migraine without aura** is a recurrent headache attack of 4 to 72 hours; typically unilateral in location, pulsating in quality, moderate to severe in intensity, aggravated by physical activity, and associated with nausea and sensitivity to light and sound.[12]
- **Migraine with aura** consists of recurrent, fully reversible attacks lasting minutes, with one or more unilateral symptoms (visual, sensory, speech and language, motor, brainstem, and retinal), usually followed by headache and other migraine symptoms.[12]
- **Chronic migraine** is headache occurring on ≥ 15 days per month for >3 months, with migraine features present on at least 8 days in a month.[13]

CLINICAL MANIFESTATIONS OF MIGRAINE

A migraine episode can be categorized into four distinct phases: the prodromal phase, which appears several hours or even days before the onset of pain; the aura phase, which directly precedes the headache; the headache phase itself; and finally the postdromal (resolution) phase, marking the end of the attack.

Prodromal Phase

This involves symptoms usually occurring 24 to 48 hours before headache onset. Common prodromal symptoms include irritability, depression, increased yawning, neck stiffness, and craving for specific foods.[9]

Aura Phase

Aura is seen in about 25% of patients with migraine. It may precede the headache, or the headache may begin together with the aura. A typical aura presents with positive or negative symptoms and is completely reversible.[9] Aura can be visual, auditory, somatosensory, or motor. Visual aura can take the form of flickering, bright lines, or a blind spot in the visual field. An auditory aura may present as tinnitus, music, or noises. Sensory aura can present as tingling, numbness, or paresthesias. Language aura is rare and can present as word-finding difficulty or trouble understanding words. Motor aura can present as weakness of one side of the face or body; this very rare form is classified as "hemiplegic migraine." [9]

Some patients experience isolated aura without the development of a migraine headache. This is called "migraine equivalent" or "acephalic migraine." [9]

Headache Phase

A migraine headache can be unilateral or bilateral. The pain is usually described as throbbing or pulsatile, and intensity can vary from moderate to severe. Headaches can be accompanied by nausea or vomiting. Many patients report phonophobia or photophobia during attacks, and they obtain relief from sleeping in a dark, quiet room.[9]

Postdromal Phase

In this phase, patients can report transient headaches on sudden head movements. Patients can also experience extreme tiredness and exhaustion.[9]

DIAGNOSIS

The diagnosis of migraine is primarily clinical, based on a detailed patient history and physical examination. The International Classification of Headache Disorders, 3rd edition (ICHD-3), provides standardized diagnostic criteria that are widely accepted for both clinical practice and research.[13]

Table-1: ICHD-3 diagnostic criteria for migraine with and without aura[13]

MIGRAINE WITH AURA	
A	At least two attacks fulfilling criteria B and C.
B	One or more fully reversible aura symptoms: visual, sensory, speech and/or language, motor, brainstem, retinal.
C	At least 3 of the following six characteristics: 1. At least 1 aura symptom spreads gradually over ≥ 5 minutes 2. Two or more aura symptoms occur in succession 3. Each individual aura symptom lasts 5–60 minutes 4. At least one aura symptom is unilateral 5. At least one aura symptom is positive 6. The aura is accompanied, or followed within 60 minutes, by headache
D	Not better accounted for by another ICHD-3 diagnosis.
MIGRAINE WITHOUT AURA	
A	At least 5 attacks fulfilling criteria B–D.
B	Headache attacks lasting 4–72 hours (when untreated or unsuccessfully treated).
C	Headache has at least 2 of the following 4 characteristics: 1. Unilateral location 2. Pulsating quality 3. Moderate or severe pain intensity 4. Aggravation by, or causing avoidance of, routine physical activity (e.g., walking or climbing stairs)
D	During headache, at least 1 of the following: (1) nausea and/or vomiting; (2) photophobia and phonophobia.
E	Not better accounted for by another ICHD-3 diagnosis.

MANAGEMENT

General Management

1. Lifestyle measures[14]

- Identify and avoid migraine triggers.
- Engage in regular physical activity to manage weight.
- Lower stress levels through relaxation techniques.
- Maintain healthy and consistent sleep patterns.
- Limit or stop caffeine intake.
- Obtain proper treatment for associated health conditions.
- Eat balanced meals at consistent times.

2. Complementary approaches[15]

- **Mind-body techniques:** behavioural or psychological therapies, biofeedback, meditation, yoga, and specific breathing exercises.
- **Manual treatments:** acupuncture, chiropractic care, and massage therapy.
- **Physical approaches:** aerobic and neck exercises.
- **Nutritional supplements:** butterbur, feverfew, magnesium, riboflavin, coenzyme Q10, and B vitamins.

HOMOEOPATHIC THERAPEUTICS FOR MIGRAINE

Remedy selection in homoeopathy rests on the totality of symptoms rather than on the disease diagnosis alone. The remedies most frequently described in the homoeopathic literature for migraine, with their characteristic indications, are given below (< = aggravated by; > = ameliorated by).

Aconitum Napellus: Burning in forehead, as if everything could be pushed out; pulsation in left side of forehead; < motion, drinking, talking, sunlight; > lying with head high.[16,17]

Belladonna: Vertigo, with falling backwards or to the left side. Sensitive to the least contact. Vertigo when stooping or rising after stooping, on every change of position. Severe throbbing and heat. Palpitation reverberating in the head with labored breathing. Pain; fullness, especially in the forehead, occiput and temple region. Rush of blood to head and face. Headache from suppressed catarrhal flow. Sudden outcries. Pain worse from light, noise, jar, lying down and in the afternoon; better by pressure and in a semi-erect position. Boring of head into the pillow; head drawn backwards and rolls from side to side. Headache worse on the right side and on lying down; ill effects from cold, etc., from having a haircut. Violent hyperemia, with throbbing carotids, red face, intolerance of least jar, noise or light; > in a dark room.[16,18]

Calcarea Carbonica: Sensation of weight on top of the head. Headache with cold hands and feet. Vertigo on ascending and on turning the head. Headache from overlifting and from mental exertion, with nausea. Head feels hot and heavy, with pale face. Icy coldness in and on the head, especially on the right side. Head enlarged; much sweating, wets the pillow. Itching of the scalp. Sensitive to light (photophobia).[16–18]

Calcarea Phosphorica: Headache, worse near the region of sutures and from change of weather, in school children around pubertal age. Headache of school girls. Headache with abdominal flatulence (sick headache). Head hot, with smarting in the roots of hair.[16–18]

Cimicifuga: Headaches often associated with the menstrual period or occurring after prolonged study or worrying. Muscles of the neck feel very stiff and painful. The person may feel mentally dull, gloomy, or even fearful during a migraine attack. Pain is aggravated by motion and is sometimes relieved by eating.[16–18]

Coffea Cruda: Relieves headaches and sleeplessness with agitation and overactive thoughts.[16]

Gelsemium: Hemispheres with dim sight or double vision; great sensitiveness to noise; coming on suddenly with vertigo; > lying with the head high on a pillow; < from exertion.[18]

Glonoinum: Violent headache from excessive use of wine, with nausea; > by vomiting.[18]

Iris Versicolor: Headache with neuralgia of infraorbital or dental nerves; nausea and watery vomiting; < towards evening and from cold air; > from motion.[18]

Lac Caninum: Pain especially over the left eye; < from noise and talking; > from rest and cold water. Neuralgic pain in the left side of the head with an empty feeling in the pit of the stomach.[17,18]

Natrum Muriaticum: Blinding headache. Pain as if a thousand little hammers were knocking on the brain, in the morning on awakening, after menstruation, from sunrise to sunset. Feels too large; cold. Headache beginning with blindness, with zig-zag dazzling like lightning before the eyes, ushering in a

throbbing headache; from eye strain. Anemic headache of school girls; nervous, discouraged, broken down. Chronic headache, semi-lateral, congestive, from sunshine to sunset, with pale face, nausea, vomiting; periodical; from eyestrain; menstrual. Before attack, numbness and tingling in lips, tongue and nose; > sleep. Attack begins in the morning in bed, diminishes after rising and moderate exercise; worse from rapid motion, accompanied by nausea and vomiting. Headache before, during and after menses; pain as if head would burst; < coughing.[16–18]

Sanguinaria Canadensis: Excessive pain with bilious vomiting; electric stitches through head, toothache, earache. Attack begins in the morning and gets worse during the day; right-sided headache more prominent; attack every seventh day.[16–18]

Spigelia: Pain beneath frontal eminence and temples, extending to eyes. Semi-lateral, involving left eye; pain violent, throbbing; worse from making a false step. Nervous headache beginning in the morning at the base of the brain, spreading over the head and locating in the eye, orbit and temple of the left side; pain pulsating, violent and throbbing. Headache at sunrise, reaching its height at noon and declining till sunset. Pain as if a band around the head. Severe pain in and around the eyes, extending deep into the sockets. Ciliary neuralgia, a true neuritis.[16–18]

Staphysagria: Stupefying headache; passes off with yawning. Brain feels squeezed. Sensation of a ball of lead in the forehead. Heat in eyeballs, dims spectacles. Bursting pain in eyeballs of syphilitic iritis.[16–18]

Theridion: Flickering before the eyes; nausea, < by closing eyes and by noise; throbbing over left eye and across forehead; sick stomach, < on rising from a lying position; desire for stimulants.[16–18]

DISCUSSION

Migraine is a common neurological disorder characterized by recurrent headaches and associated symptoms such as nausea, photophobia, and phonophobia, significantly affecting quality of life and daily functioning. Early diagnosis and appropriate management are important for reducing disease burden and preventing recurrent attacks. Homoeopathic management emphasizes an individualized approach, considering the totality of symptoms, constitutional characteristics, and patient susceptibility. The remedies discussed in this review illustrate the therapeutic application of homoeopathic principles in migraine, where remedy selection is guided by characteristic symptom patterns rather than by the disease diagnosis alone. This individualized approach highlights the potential role of homoeopathy in the management of migraine.

CONCLUSION

Migraine is a multifactorial neurological disorder with diverse clinical manifestations and triggering factors. Early diagnosis and appropriate management are essential to reduce disease burden and improve patient outcomes. Homoeopathy offers an individualized and holistic approach based on the patient's constitutional characteristics and symptom totality. Available literature suggests that homoeopathic therapeutics may help reduce the frequency and severity of migraine attacks and improve overall well-being. However, further high-quality clinical studies are needed to establish their effectiveness. An integrated, patient-centred approach may contribute to better long-term outcomes and enhanced quality of life in individuals with migraine.

ACKNOWLEDGEMENTS

The authors acknowledge the researchers and authors whose published works were consulted during the preparation of this review article.

ETHICAL APPROVAL

Not applicable. This article is a review of previously published literature and did not involve human participants, animals, or identifiable patient data.

REFERENCES

1. Burch RC, Buse DC, Lipton RB. Migraine: epidemiology, burden, and comorbidity. *Neurol Clin.* 2019;37(4):631–649.
2. Ernst E. Complementary or alternative therapies for migraine: what the evidence tells us. *Cephalalgia.* 2011;31(6):638–645.
3. Sharda S, Shivangi, Kaur A, Kaur R, Singh M. Exploring the scope of individualized and therapeutic approach for management of migraine with homoeopathy: a literature review. *J Popul Ther Clin Pharmacol.* 2025;32(3):160–167.
4. Pescador Ruschel MA, De Jesus O. Migraine headache. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025.
5. Silberstein SD, Lipton RB, Goadsby PJ. Headache in clinical practice.
6. Kumar P, Clark M. Neurological disease. In: Kumar and Clark's Clinical Medicine.
7. Golwalla AF, Golwalla SA. Neurology. In: Golwalla's Medicine. 23rd ed. 2011. p. 438–439.
8. Raieli V, Raimondo D, Cammalleri R, Camarda R. Migraine headaches in adolescents: a student population-based study in Monreale. *Cephalalgia.* 1995;15(1):5–12. doi:10.1046/j.1468-2982.1995.1501005.x
9. Kikkeri NS, Nagalli S. Migraine with aura. In: StatPearls. StatPearls Publishing; 2022.
10. Hoffmann J, Baca SM, Akerman S. Neurovascular mechanisms of migraine and cluster headache. *J Cereb Blood Flow Metab.* 2019;39(4):573–594. doi:10.1177/0271678X17733655
11. Bates B, et al. A guide to physical examination and history taking. 6th ed. Philadelphia: J.B. Lippincott Company; 1995. p. 62–65.
12. Eigenbrodt AK, Ashina H, Khan S, Diener HC, Mitsikostas DD, Sinclair AJ, et al. Diagnosis and management of migraine in ten steps. *Nat Rev Neurol.* 2021;17(8):501–514. doi:10.1038/s41582-021-00509-5
13. Headache Classification Committee of the International Headache Society (IHS). The International Classification of Headache Disorders, 3rd edition (ICHD-3). *Cephalalgia.* 2018;38(1):1–211. Available from: <https://ichd-3.org>
14. Agbetou M, Adoukonou T. Lifestyle modifications for migraine management. *Front Neurol.* 2022;13:719467. doi:10.3389/fneur.2022.719467
15. Haghdoost F, Togha M. Migraine management: non-pharmacological points for patients and health care professionals. *Open Med (Wars).* 2022;17(1):1869–1882. doi:10.1515/med-2022-0598
16. Boericke OE. Pocket manual of homoeopathic materia medica with repertory. 9th ed. New Delhi: B. Jain Publishers; 2013.
17. Lilienthal S. Homoeopathic therapeutics. 2nd ed. New Delhi: B. Jain Publishers; 2003.
18. Allen HC. Allen's keynotes rearranged and classified with leading remedies of the materia medica and bowel nosodes. 10th ed. New Delhi: B. Jain Publishers (P) Ltd; 2016.

How to cite this article: Alpana Choudhary, Pallavi Gupta, Homoeopathic Therapeutics in Migraine: A Comprehensive Review, *Nat J. Med. Res. Yoga Sci.*, 2026; 3 (4): 14-174

Source of Support: Nil, **Conflicts of Interest:** None declared.