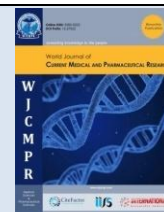




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INDIVIDUALIZED HOMOEOPATHIC MANAGEMENT OF A LEFT ORBITAL APEX LESION WITH HEADACHE AND VISUAL IMPAIRMENT: A CASE REPORT

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ARTICLE HISTORY	ABSTRACT
Received on: 06-08-2026 Revised on: 26-08-2026 Accepted on: 06-10-2026	Background: Orbital apex lesions may present with unilateral headache and visual impairment. Their clinical course and radiological findings require careful interpretation because inflammatory and neoplastic conditions may have overlapping presentations.
Keywords: Tolosa-Hunt syndrome, Individualized Homoeopathic Medicine, Belladonna, visual Impairment, orbital apex lesion.	Case Presentation: A 33-year-old woman attended a private homoeopathic clinic on 24 January 2020 with severe left temporal and supraorbital headache, nausea, facial redness and congestion, visual impairment, and debility. Baseline MRI demonstrated a 37 × 18 × 12 mm enhancing left orbital apex lesion with optic nerve compression and cavernous sinus extension. A provisional diagnosis of Tolosa-Hunt syndrome was made on clinical assessment. The patient had previously used an analgesic. Individualized Belladonna 10M was prescribed as a single dose and repeated once following symptom recurrence, with placebo between prescriptions. During follow-up, headache and associated symptoms resolved, and on clinical follow-up, complete recovery of vision was reported. At the final documented consultation on 20 February 2021, the patient was free from her presenting complaints. Follow-up MRI described a persistent lesion measuring 17.4 × 11.7 × 13.7 mm, with a smaller maximum reported dimension and an impression of possible meningioma. Financial constraints prevented further investigation.
Corresponding Author Dr. Tanudipta Halder Assistant Professor, Department of Research Methodology and Biostatistics (P.G.), L. R. Shah Homoeopathy College, Rajkot, Gujarat, India.	Conclusion: This case documents complete clinical remission of the presenting complaints during individualized homoeopathic care, accompanied by a smaller maximum reported dimension of a persistent orbital apex lesion. Clinical recovery did not establish the lesion's underlying pathology or a causal treatment effect.

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INTRODUCTION

Orbital apex lesions can affect structures involved in vision and ocular movement. An enhancing lesion associated with unilateral headache raises a differential diagnosis that includes inflammatory, neoplastic, and infectious disease. Tolosa-Hunt syndrome (THS) is characterized by unilateral orbital or periorbital pain and ipsilateral ocular motor nerve paresis associated with granulomatous inflammation in the cavernous sinus, superior orbital fissure, or orbit [1]. MRI findings at the orbital apex and cavernous sinus may overlap among THS, idiopathic orbital inflammation, meningioma, lymphoma, and sarcoidosis [2]. Imaging series

emphasize interpretation alongside clinical findings and longitudinal assessment [3]. This report describes complete clinical remission of presenting complaints during individualized homoeopathic care in a patient with a left orbital apex lesion and an initial clinical working diagnosis of THS. The clinical recovery and subsequent imaging findings are presented separately, following the CARE reporting framework [4].

CASE PRESENTATION

Patient information and presenting complaints

A 33-year-old woman presented to a private homoeopathic clinic on 24 January 2020 with a 4–5 month history of

severe left-sided headache. Pain involved the left temporal and supraorbital regions and had become particularly severe during the preceding five days. The attacks were throbbing, sudden in onset, and short in duration, with a rapid rise and fall in intensity. Noise and lying down aggravated the pain; firm pressure or massage relieved it. Associated symptoms included nausea, subjective visual impairment in the left eye, facial redness and congestion, and general debility.

No significant past medical or family history was reported. Before starting homoeopathic treatment, the patient had taken a painkiller for the presenting symptoms. The analgesic name, dose, frequency, duration, response, and discontinuation date could not be established from the available information. Appetite was slightly reduced, with a preference for spicy food and aversion to milk and sour foods. Thirst and perspiration were moderate, and sleep was adequate. The tongue was described as white-coated, with a clean tip and tooth impressions at the margins. The patient sought company, wept easily, and reported irritability and anxiety about her illness.

Clinical Findings

Following clinical assessment, a provisional diagnosis of Tolosa-Hunt syndrome (THS) was considered. The patient was alert, conscious, and cooperative, with normal speech, bilateral muscle strength of 5/5, and intact sensation.

Diagnostic Assessment

Contrast-enhanced MRI of the brain and orbits dated 21 December 2019 described an intensely enhancing plaque-like lesion measuring $37 \times 18 \times 12$ mm at the left orbital apex. The lesion compressed the orbital contents, including the optic nerve, and extended minimally anteriorly along the thickened lateral and superior recti. Extension into the superior and inferior orbital fissures, posteriorly into the cavernous sinus, and posterolaterally along the anterior middle cranial fossa was reported, with compression of the adjacent temporal lobe. The available baseline report is represented by Figure 1.

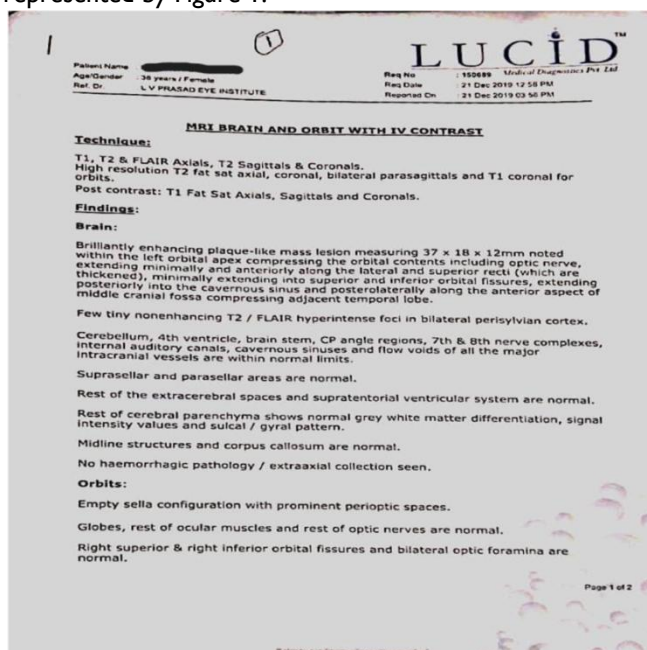


Figure 01: Baseline contrast-enhanced MRI report dated 21 December 2019 describing a $37 \times 18 \times 12$ mm left orbital apex lesion with optic nerve compression and extension into the orbital fissures, cavernous sinus, and adjacent middle cranial fossa.

Ipsilateral supraorbital pain and an enhancing orbital apex lesion extending into the cavernous sinus supported consideration of a provisional diagnosis of Tolosa-Hunt syndrome (THS). The diagnosis was clinical and remained a working diagnosis [1]. No tissue diagnosis was obtained. The available baseline MRI report is reproduced in Figure 01.

Homoeopathic assessment and intervention

The homoeopathic assessment considered the headache characteristics, congestion, nausea, sensory sensitivity, emotional features, food preferences, and tongue findings. Repertorisation was performed using the Synthesis Repertory in RADAR software version 10.0. Lycopodium, Phosphorus, Belladonna, and Nux vomica were the leading medicines identified. Belladonna was selected after comparison of the symptom totality with the homoeopathic materia medica. The repertorial analysis is shown in Figure 02.

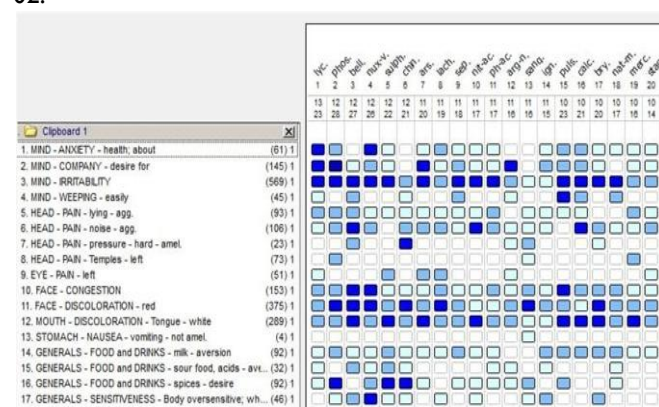


Figure 02: Repertorial analysis using the Synthesis

Repertory in RADAR software version 10.0, showing the selected rubrics and comparative remedy coverage.

Belladonna 10M was administered as a single dose on 24th January 2020 and repeated on 7th June 2020 following recurrence of headache and nausea. Placebo globules were prescribed between the active doses and at subsequent follow-up visits, at a regimen of two globules of no. 40 orally each morning for 30 days.

Follow up and outcomes

At the first follow-up, facial redness and congestion had resolved and headache episodes had become infrequent. By March 2020, headache and facial redness were no longer reported. Intermittent symptoms recurred later, including an increase in headache and nausea in June 2020, prompting the second Belladonna prescription. Subsequent visits recorded improvement, with occasional nausea or mild headache. At the final documented consultation on 20 February 2021, the presenting complaints had resolved and general well-being had improved. Complete recovery of left-eye vision was reported during clinical follow-up. At the final documented consultation, the presenting complaints had resolved and general well-being had improved. Follow-up MRI dated 13 February 2021 described a homogeneously enhancing flat lesion measuring $17.4 \times 11.7 \times 13.7$ mm at the left orbital apex. The lesion was inseparable from the lateral rectus, compressed the optic nerve, and extended to the meningeal lining over the anteroinferior temporal lobe and parasellar region. The radiological impression was "possible meningioma at left orbital apex." Further investigation was not feasible because of the patient's financial circumstances, and the underlying

pathology remained unresolved. The follow-up MRI report is presented in Figure 03.

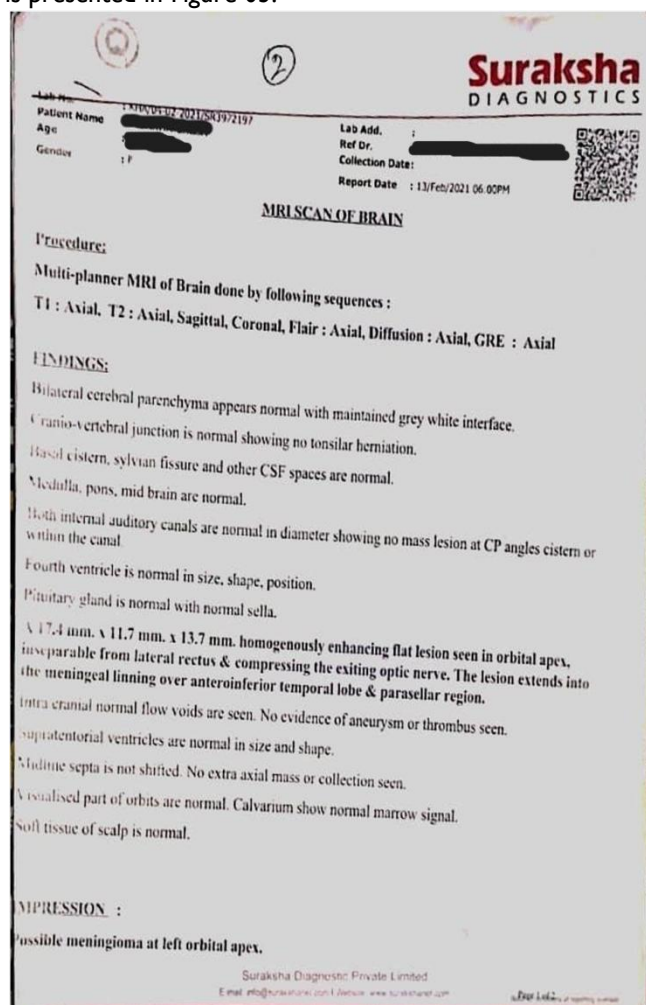


Figure 03: Follow-up MRI report dated 13 February 2021 describing a persistent 17.4 × 11.7 × 13.7 mm left orbital apex lesion with optic nerve compression and meningeal extension. The radiological impression was possible meningioma.

Table 01: Timeline of the documented episode of care

Date	Reported clinical course	Intervention
24 Jan 2020	Initial presentation with severe left-sided throbbing headache, nausea, facial redness and congestion, subjective visual impairment in the left eye, and general debility.	Belladonna 10M, single dose; followed by placebo, two globules 40 no. once each morning for 30 days.
24 Feb 2020	Facial redness and congestion had resolved; headache paroxysms were very few; nausea occurred intermittently; irritability had markedly decreased.	Placebo, two globules 40 no. once each morning for 30 days.
17 Mar 2020	No headache or facial redness; nausea not reported.	Placebo, two globules 40 no. once each morning for 30 days.

28 May 2020	Headache occurred intermittently; nausea was rare; no facial redness; general debility improved.	Placebo, two globules 40 no. once each morning for 30 days.
07 Jun 2020	Headache paroxysms increased; nausea became prominent without vomiting; malaise was reported.	Belladonna 10M, single dose; followed by placebo, two globules 40 no. once each morning for 30 days.
21 Sep 2020	Headache paroxysms decreased; nausea was inconsistent; general debility was absent.	Placebo, two globules 40 no. once each morning for 30 days.
30 Oct 2020	No recurrence of the main complaints; occasional nausea.	Placebo, two globules 40 no. once each morning for 30 days.
14 Dec 2020	Slight headache for a few days with irritability and malaise.	Placebo, two globules 40 no. once each morning for 30 days.
20 Feb 2021	Complete clinical remission of presenting complaints; general well-being improved.	Placebo, two globules 40 no. once each morning for 30 days.

DISCUSSION

Clinical and diagnostic context

The main clinical observation was complete remission of the presenting complaints during individualized homeopathic care. Early improvement in headache and facial redness and congestion was followed by intermittent symptom recurrence. Belladonna was repeated when headache and nausea increased in June 2020. Subsequent follow-up documented improvement, and at the last consultation the patient was free from the presenting complaints. Complete recovery of vision was reported during clinical follow-up. This favorable clinical course is distinct from the persistence of an enhancing lesion on MRI. The initial consideration of THS was supported by the anatomical distribution of the lesion and ipsilateral orbital-region pain. Nevertheless, THS is a clinical-radiological syndrome requiring evidence of granulomatous inflammation and ipsilateral ocular motor nerve paresis, with the required temporal relationship and exclusion of another diagnosis [1]. The reported visual impairment and optic nerve compression are relevant clinical features, but do not themselves establish ocular motor nerve paresis. The diagnosis is therefore presented as a provisional clinical diagnosis of Tolosa-Hunt syndrome.

The follow-up radiologist's impression of possible meningioma is important because it offers an alternative explanation for the persistent lesion. Enhancement and meningeal extension are not sufficient to resolve its nature. MRI findings in THS can overlap with other inflammatory and neoplastic conditions [2]. The imaging literature

supports correlation with the clinical presentation and follow-up findings [3]. No definitive diagnosis of the lesion was established.

The differential diagnosis also includes idiopathic orbital inflammation, lymphoma, and sarcoidosis, as well as infectious causes of painful orbital syndromes [1,2]. Clinical improvement alone does not distinguish these conditions. Financial constraints prevented further investigation in this patient; consequently, the report describes an unresolved orbital apex lesion alongside a favorable symptomatic outcome.

Clinical and radiological outcomes

The two MRI reports document measurements of $37 \times 18 \times 12$ mm and $17.4 \times 11.7 \times 13.7$ mm. The maximum reported dimension was smaller on follow-up; the three dimensions were not uniformly reduced. These measurements are reported descriptively. They do not demonstrate complete radiological resolution, and direct volumetric comparison was not possible without the original image datasets.

The reported restoration of vision and resolution of other symptoms are clinically meaningful outcomes. Their coexistence with a persistent imaging abnormality illustrates why symptomatic recovery and structural resolution should be assessed separately. The case supports a description of complete clinical remission of the presenting complaints, rather than a claim that the orbital apex lesion was cured.

Interpretation and limitations

The treatment was selected on the basis of the individual symptom profile and repertorial assessment. The reported improvement occurred during the period of care, but this uncontrolled observation cannot establish causation. Natural symptom fluctuation, spontaneous improvement, regression to the mean, prior analgesic exposure, contextual effects, and unrecorded co-interventions remain possible explanations. These possibilities do not negate the recorded clinical recovery; they limit attribution of that recovery to a specific treatment.

The report is supported by a dated clinical timeline, serial radiological reports, and a repertorial chart. The case should be interpreted as a clinical observation rather than evidence establishing efficacy of Belladonna or homoeopathy for THS, meningioma, or another orbital apex disorder.

CONCLUSION

This case documents complete clinical remission of headache, associated symptoms, and reported visual impairment during individualized homoeopathic care for a left orbital apex lesion. Follow-up MRI demonstrated a persistent lesion with a smaller maximum reported dimension and an impression of possible meningioma. Although the patient recovered clinically, the underlying pathology remained unresolved and further investigation was limited by financial constraints. The report describes a favorable clinical course without establishing a causal treatment effect.

DECLARATION OF PATIENT CONSENT

The authors confirm that written consent was obtained from the patient for publication of her clinical information and accompanying radiological reports. The patient understood that her name and initials would not be published and that efforts would be made to protect her

identity, although complete anonymity cannot be guaranteed.

ETHICAL CONSIDERATIONS

This report concerns an individual patient treated in routine private-clinic practice. Written consent for publication was obtained as described above.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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No financial support or sponsorship was received.

AUTHOR CONTRIBUTIONS

All authors contributed equally to this case report.

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REFERENCES

1. Headache Classification Committee of the International Headache Society (IHS) The International Classification of Headache Disorders, 3rd edition. Cephalalgia. 2018 Jan;38(1):1-211. doi: 10.1177/0333102417738202. PMID: 29368949.
2. Yousem DM, Atlas SW, Grossman RI, Sergott RC, Savino PJ, Bosley TM. MR imaging of Tolosa-Hunt syndrome. AJNR Am J Neuroradiol. 1989 Nov-Dec;10(6):1181-4. PMID: 2512779; PMCID: PMC8332429.
3. Schuknecht B, Sturm V, Huisman TA, Landau K. Tolosa-Hunt syndrome: MR imaging features in 15 patients with 20 episodes of painful ophthalmoplegia. Eur J Radiol. 2009 Mar;69(3):445-53. doi: 10.1016/j.ejrad.2007.11.034. Epub 2007 Dec 31. PMID: 18166288.
4. Riley DS, Barber MS, Kienle GS, Aronson JK, von Schoen-Angerer T, Tugwell P, Kiene H, Helfand M, Altman DG, Sox H, Werthmann PG, Moher D, Rison RA, Shamseer L, Koch CA, Sun GH, Hanaway P, Sudak NL, Kaszkin-Bettag M, Carpenter JE, Gagnier JJ. CARE guidelines for case reports: explanation and elaboration document. J Clin Epidemiol. 2017 Sep;89:218-235. doi: 10.1016/j.jclinepi.2017.04.026. Epub 2017 May 18. PMID: 28529185.