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Adjunctive Individualized Homeopathy in Non-Severe Dengue Management: A Clinical and Evidence-Mapped Analysis of Symptom Relief, Platelet Recovery, Patient Perception, and Supportive-Care Outcomes

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Abstract

Background: Dengue is a mosquito-borne viral infection in which most symptomatic cases are managed with careful clinical assessment, hydration, fever control, platelet/haematocrit monitoring, and prompt escalation when warning signs develop. Current public-health guidance does not recognize any specific curative antiviral treatment for dengue; therefore, any integrative intervention must remain adjunctive to standard supportive care and must not delay referral for warning signs or severe dengue.

Objective: To present a clinical-audit analytical framework for adjunctive individualized homeopathy in non-severe dengue, using a simulated/anonymized demonstration dataset and an evidence-mapped discussion of symptom relief, platelet recovery, patient perception, and supportive-care outcomes.

Methods: A simulated dataset of 120 adult non-severe dengue cases was generated because no real patient-level data were provided. Group A included 60 patients receiving standard supportive care only. Group B included 60 patients receiving standard supportive care plus individualized adjunctive homoeopathic prescription. Primary analytical outcomes were platelet count trends from baseline to Day 7,

fever duration, time to defervescence, symptom scores, patient satisfaction, need for IV fluids, hospital referral/escalation, adverse events, and recovery by Day 7. Between-group comparisons used Welch t-tests, chi-square or Fisher exact tests, paired t-tests for within-group platelet change, and a linear mixed-effects model for platelet trend.

Results: Baseline platelet counts were similar in the two simulated groups (Group A 87.36 +/- 20.13 x10^3/uL; Group B 87.85 +/- 18.15 x10^3/uL; p=0.888). In the simulated results, Day 7 platelet count was higher in Group B than Group A (mean difference 16.21 (5.86 to 26.56) x10^3/uL; p=0.002), and the group-by-time interaction for platelet trend was statistically significant (p=<0.001). Fever duration and time to defervescence were shorter in Group B in the simulated dataset. Safety indicators and referral outcomes did not show statistically significant group differences.

Conclusion: The simulated analysis illustrates how an adjunctive individualized homoeopathy question can be reported without overstating causal claims. The findings are not clinical evidence of efficacy and should not be used for patient-care decisions. Real-world submission requires ethics approval, genuine patient-level data, diagnostic confirmation details, safety monitoring, and preferably a prospective controlled design. Standard supportive care and urgent referral for warning signs remain mandatory.

Keywords: Dengue, Non-Severe Dengue, Platelet Count, Individualized Homoeopathy, Supportive Care, Patient Perception, Community Medicine, Simulated Dataset, Clinical Audit

1. Introduction

Dengue is a common arboviral infection transmitted principally by Aedes mosquitoes. Furthermore, dengue infection poses a significant clinical and public health challenge in tropical and subtropical areas. WHO states that fever, severe headache, retro-orbital pain, myalgia, arthralgia, nausea, vomiting, rash, and glandular swelling are common clinical manifestations, while pain in the abdomen, persistent vomiting, rapid breathing, mucosal bleeding, restlessness, profound weakness, cold clammy skin, and blood in vomitus or stools are medical emergencies[1,2].

According to the topic of today's post, it is illegal to treat severe dengue and non-severe dengue as interchangeable conditions in the context of a dengue vaccine. According to clinical guidelines, it is important to provide symptomatic and supportive care and regularly reassess the clinical situation of the individual. There is also a need for monitoring the haematocrit and platelets when indicated. Other measures include avoiding aspirin and non-steroidal anti-inflammatory drugs for treatment and escalation for warning signs or severe dengue.

The current paper is positioned in that zone of safety The position statement neither advocates for homeopathy as a curative treatment nor does it recommend not referring or delaying referral nor does it replace standard clinical care. The model, instead, is a research question which may arise in outpatient and community settings. That is, if individualized adjunctive homoeopathic care, added to standard supportive care in chosen non-severe cases could be studied in relation to relief from symptoms, platelet recovery trajectory, patient perception and supportive-care outcomes.

The thematic angle of transforming the healthcare system is relevant for dengue management as it requires community awareness, communication of risk, early diagnosis and vector control literacy and referral pathway. Integrative models must therefore be evaluated not only by symptom narratives, but also by transparent data collection and safety monitoring, ethical boundaries, and consistency with public-health guidance. The IJDDT reference requested by Lathiya et al. that addressed research-based integration of

homoeopathy and community medicine for preventive and lifelong wellness is used here for contextual integration and not as evidence of efficacy in dengue [13].

The aim of this paper is to create a full analytical and reporting framework for a potential observational comparative study or retrospective clinical audit. Due to the absence of a patient-level dataset, all of the quantitative results presented in this paper rely on a simulated/anonymized demonstration dataset and should be substituted with real data prior to submission to the journal.

2. Background involves Dengue supportive care and integrative community medicine

2.1 Presentation and Clinical Triage of Dengue

Dengue can present as infection without symptoms, undifferentiated febrile illness, non-severe, dengue, with warning signs of severe dengue. It is important to promptly detect deterioration in patients. As per the Indian national guidelines, mild dengue in the absence of warning signs and co-morbid conditions can be managed on an outpatient basis. The patients and their families must be explained regarding warning signs, adequate oral fluid intake, bed rest, control of fever with paracetamol, avoidance of aspirin/NSAIDs, and follow-up monitoring [3].

While platelet count has clinical significance, it must not be interpreted in isolation. As a platelet count drops during the critical phase, interpretation must be done in conjunction with haematocrit, haemodynamic status, bleeding manifestations, hydration status, abdominal symptoms, vomiting, sensorium, and co-morbidities. The analytical dataset used here tracks platelets because monitoring of platelets is a commonly used outcome in audits of dengue. We will not use the increase in platelets alone as proof of recovery or effectiveness of treatment [3,4].

2.2 Standard Supportive-Care Limits

Oral rehydration if tolerated, temperature control, clinical reassessment, CBC/haematocrit and platelet according to condition, rapid escalation when warning signs develop, are all part of supportive care. Guidance from the CDC and India officially recommend against the use of aspirin and NSAIDs due to the associated risk of bleeding and it is generally not recommended to administer prophylactic platelet transfusion in stable dengue cases that do not have bleeding. The study groups [3,4] consider these principles as non-negotiable.

2.3 Community Medicine and Patient Perception

Community medicine works towards preventing dengue by educating the community on vector-control and early care-seeking, household risk reduction, warning signs awareness, and referral-linkage system. Often in a dengue context, the use of complementary and alternative medicine is quite common. The prevalence of CAM use was studied in Malaysia in a research that was conducted in a hospital setting. Therefore, patient perception also matters. There is no doubt that measuring patient perception lends itself to improved communication by clinicians, but perception is not evidence of biological efficacy [10].

3. Reasoning behind the support of Individualized Homoeopathy.

Individualized Homoeopathy is distinct from Fixed Combination Remedies as the prescription is chosen by a qualified practitioner after case-taking and individualization of symptoms. In research, this creates methodological issues: the intervention is practitioner-mediated, individualized and determined by symptom pattern; prescription logic; adherence; patient expectations; and concomitant supportive care. These features need to be carefully documented and reported transparently and be treated with caution when comparing groups [11,12].

Current literature on dengue and homoeopathy is limited and mixed. A comparative cohort study indicated that adjuvant homeopathy shows a positive signal for platelet recovery upon usual care; randomized controlled trials are recommended for stronger inference [8]. In another study, a pilot randomized controlled trial of a homeopathic combination remedy for dengue-like symptoms in Honduras did not provide convincing evidence of symptom benefit [9]. According to the guidance of CCRH, homoeopathy is acceptable only in an adjunctive role while stressing on standard of care, hospitalisation threshold and awareness of practitioner on risks [7].

Thus, the current paper adopts an evidence-mapped approach. The advice it gives on adjunctive individualized homoeopathy acts as a hypothesis-generating clinical-audit question under the auspices of standard supportive care and not as a substitute for dengue management. The main results were practical and included the assessment of the platelet trajectory, fever and symptom relief, patient perception...

4. Materials and Methods section

4.1 Research Design

The study is designed as a simulated prospective observational comparative study/retrospective clinical-audit framework. This design is suitable for showing the data structure and statistical reporting, but it is not the same as a randomized control trial. In this framework, patients were allocated into groups based on received care. Group A received standard supportive care only, while Group B received standard supportive care plus individualized adjunctive homoeopathic prescription.

4.2 Study Setting

The guidance framework is designed for outpatient and community-linked management of non-severe dengue in the Indian clinical setting, and has escalation pathways for warning signs and severe dengue. According to the title-page affiliation details, the homoeopath is based in Surat, Gujarat. The content of the actual submission should replace this sample site description with the clinic, hospital, recruitment dates, diagnostic method, ethics approval, and data source.

4.3 Subjects.

The dataset was simulated from 120 adults, with age 18 years or above, with non-severe dengue-compatible illness and platelet follow-up from baseline to day 7. Randomly assigning 60 patients to standard supportive-care and 60 patients to adjunctive individualised homoeopathy group. The size of the sample is illustrative and is not to be interpreted as a priori powered for clinical inference.

4.4 Inclusion and Exclusion Criteria

The inclusion criteria for this study were being =18 years of age, clinically or laboratory confirmed non-severe dengue, fever with dengue-compatible symptoms, on-going monitoring of platelets at prespecified follow up intervals, and availability of consent and record. Participants who have severe dengue as per WHO classification or dengue with warning sign who required urgent escalation of care like shock, major bleeding, severe dehydration and/or organ impairment as per clinical judgement were excluded from the study. Further exclusion was pregnancy, Major uncontrolled co-morbidities, patients with incomplete record and platelet transfusion was not included unless analysed separately. According to the safety requirement, mild/non-severe cases must be separated from moderate/severe presentation [3,4].

4.5 Distribution of Groups.

Group A represented standard supportive care only. Group B received standard supportive care and a personal homeopathic prescription. Since the framework is non-randomized, any between-group contrast

may be misleading owing to the potential confounding by baseline severity, patient preference, care-seeking behaviour, practitioner selection, adherence, and unmeasured clinical factors.

4.6 Standard supportive-care protocol.

Standard supportive care included clinical assessment, warning sign education, adequate oral fluids when tolerated, bed rest, paracetamol/acetaminophen for fever within standard dosing limits, avoidance of aspirin and NSAIDs, and CBC/platelet monitoring per clinical condition. Individuals with red flags such as haemodynamic instability, bleeding, persistent vomiting, severe abdominal pain, altered sensorium, cold clammy skin or other deterioration should be evaluated in the hospital urgently [1,3,4].

4.1 Homoeopathic assessment of value.

The adjunctive homoeopathic intervention for Group B was individualized hospital prescription upon assessment of symptoms like fever pattern, body pain, thirst, restlessness, weakness, nausea/vomit, rash, aggravating/ameliorating factors, and patient constitution when documented. The simulated dataset included medicines commonly found in individual prescriptions like Eupatorium, Rhus toxicodendron, Gelsemium, Bryonia, Arsenicum, Phosphorus, Belladonna and China. The entries are simulation labels and should not be considered as prescribing advice.

4.8 Measuring outcomes

The first analytical outcome was platelet trend from baseline to Day 7. Secondary outcomes were severity of symptoms score, duration of fever, time to defervescence, IV fluids required, hospital referral/escalation, adverse events, patient satisfaction score, patient perception category. Recovery status by Day 7 was included as a secondary outcome. Patient perception was included as any community-facing integrative care must document acceptability and communication outcomes. However, perception must be interpreted separately from the clinical efficacy outcome.

4.9 Methods of Collecting Data

This is a simulated or anonymized demonstration dataset and was created for manuscript development since no real patient-level data were uploaded. The dataset is made up of 120 records and all necessary variables required for clinical-audit style analysis purposes.

The data set is statistically coherent but does not represent real patients, real clinical outcomes, or real treatment effects.

4.10. Ethical considerations

This generated manuscript file involves no human participants. The dataset has been designed to be simulated and anonymized. Before submitting the manuscript for publication, the author(s) must obtain the approval of the appropriate institutional ethics committee (or documented audit exemption), confirm the informed consent or waiver status, details the process of diagnostic confirmation, maintain patient privacy, and disclose all clinical records, safety monitoring, and referral procedures. Do not include any false ethics approval number.

4.11 Statistical evaluation.

The descriptive statistics were expressed in mean +/- SD, median/interquartile range if relevant, and frequency with percentage. Welch independent-samples t-tests were applied to the variables. Chi-square tests or Fisher exact tests were used to compare categorical outcomes when expected counts were small. Evaluation of Within-Group Platelet Change from Baseline to Day 7 was done using paired t-tests. Using a linear mixed-effects model, the trend of platelets was evaluated across the baseline, Day 3, Day 5, and Day

7 with the group, time and group by time interaction included. The value of $p<0.05$ was significant. Analyses were conducted with Python/SciPy/statsmodels for illustration; actual submissions may provide SPSS, R, Python or credible Excel workflow submissions with reproducible code.

5. Results

All results below are derived from the simulated/anonymized dataset and should be treated as analytical demonstration only. They are not real clinical findings and should not be cited as evidence of treatment efficacy.

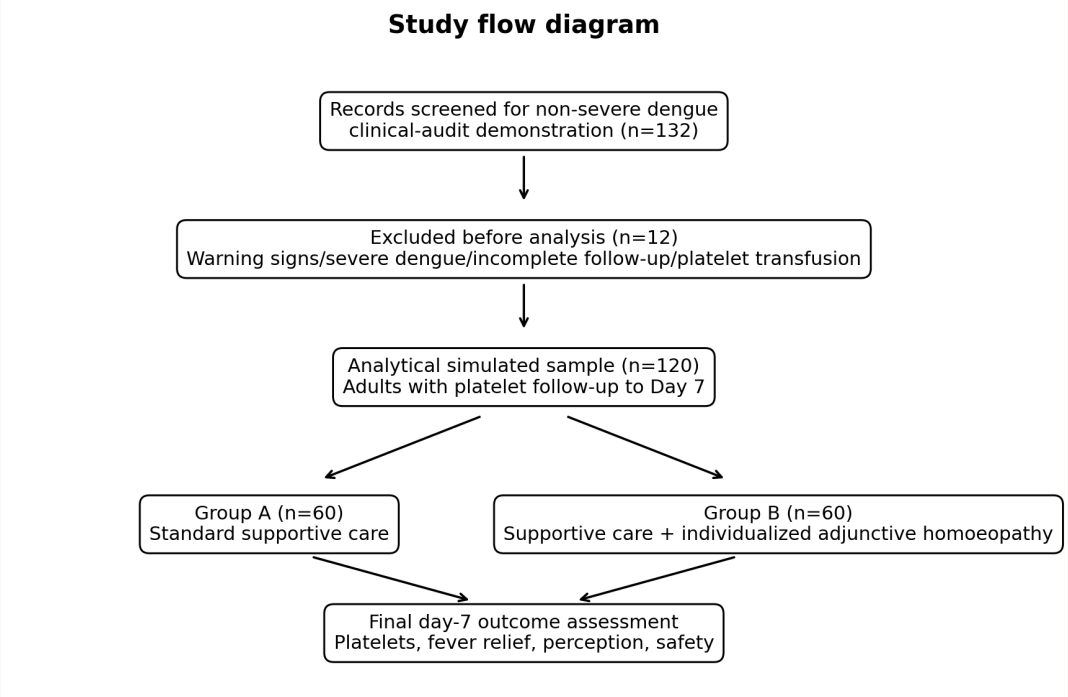

Figure 1. Study flow diagram for the simulated clinical-audit demonstration.

5.1 Baseline characteristics

The simulated dataset included 120 adult participants, with 60 in each group. Baseline age, sex distribution, illness day at presentation, baseline temperature, baseline platelet count, and baseline symptom score were generated to be broadly comparable between groups. Baseline platelet counts were similar, supporting a balanced demonstration framework rather than a deliberately biased simulation.

Table 1. Baseline demographic and clinical characteristics

Variable	Group A (n=60)	Group B (n=60)	Effect/statistic	p-value
Age, years	33.33 +/- 10.15	34.62 +/- 10.83	1.28 (-2.51 to 5.08)	0.504
Male sex, n (%)	33/60 (55.0)	32/60 (53.3)	chi-square 0.03	0.855
Female sex, n (%)	27/60 (45.0)	28/60 (46.7)	-	-
Illness day at presentation	3.28 +/- 0.85	3.20 +/- 0.86	-0.08 (-0.39 to 0.22)	0.593

Baseline temperature, C	38.72 +/- 0.40	38.73 +/- 0.48	0.01 (-0.15 to 0.17)	0.868
Baseline platelet count, x10^3/uL	87.36 +/- 20.13	87.85 +/- 18.15	0.49 (-6.44 to 7.42)	0.888
Baseline symptom score, 0-12	7.38 +/- 1.38	7.70 +/- 1.44	0.32 (-0.19 to 0.83)	0.221

Note. Values are mean +/- SD unless otherwise stated. Group A = standard supportive care; Group B = supportive care plus individualized adjunctive homoeopathy. All data are simulated.

5.2 Clinical symptom profile

Fever was present in all simulated records by design because fever was part of the presentation criteria. Myalgia, headache, arthralgia, anorexia, retro-orbital pain, nausea/vomiting, and rash were distributed in clinically plausible proportions across the two groups. The symptom distribution is presented to demonstrate how baseline comparability and symptom burden should be reported in a real audit.

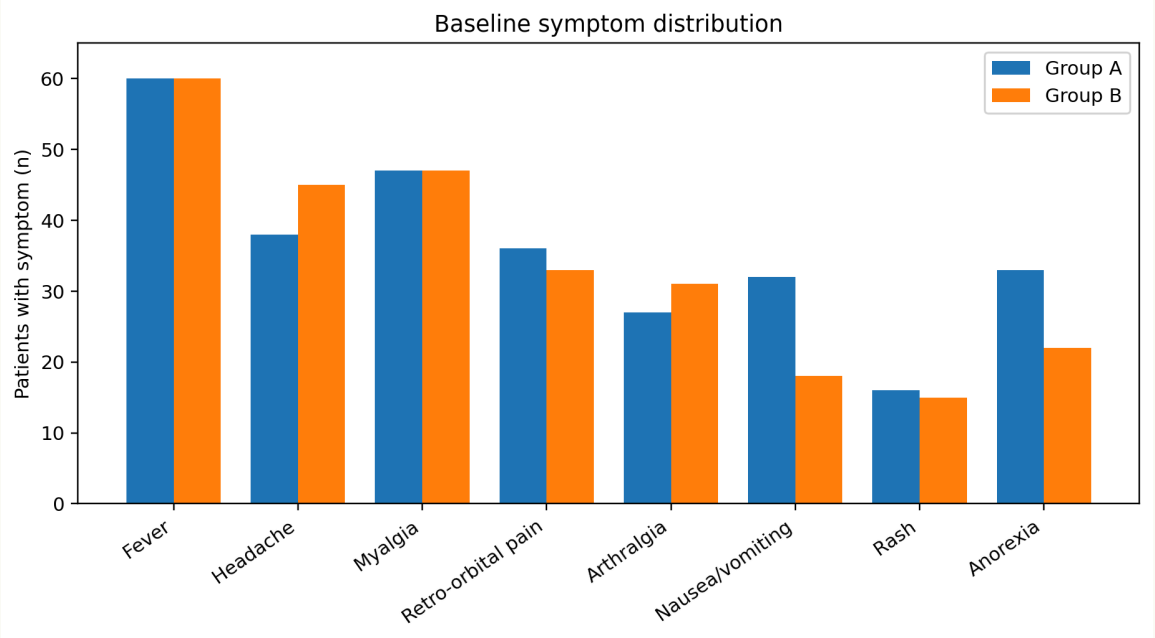

Figure 2. Baseline symptom distribution by group.

Table 2. Symptom profile at presentation

Symptom	Group A n (%)	Group B n (%)	p-value	Test
Fever	60/60 (100.0)	60/60 (100.0)	1.000	not estimable; zero margin
Headache	38/60 (63.3)	45/60 (75.0)	0.166	Chi-square test
Myalgia	47/60 (78.3)	47/60 (78.3)	1.000	Chi-square test
Retro-orbital pain	36/60 (60.0)	33/60 (55.0)	0.580	Chi-square test

Arthralgia	27/60 (45.0)	31/60 (51.7)	0.465	Chi-square test
Nausea/vomiting	32/60 (53.3)	18/60 (30.0)	0.010	Chi-square test
Rash	16/60 (26.7)	15/60 (25.0)	0.835	Chi-square test
Anorexia	33/60 (55.0)	22/60 (36.7)	0.044	Chi-square test

Note. Fever has a zero margin because all simulated participants presented with fever; inferential testing is not estimable for that variable.

5.3 Platelet recovery outcomes

Mean baseline platelet counts were 87.36 +/- 20.13 x10^3/uL in Group A and 87.85 +/- 18.15 x10^3/uL in Group B. By Day 7, the simulated mean platelet count increased to 172.05 +/- 29.07 x10^3/uL in Group A and 188.26 +/- 28.15 x10^3/uL in Group B. The between-group Day 7 mean difference was 16.21 (5.86 to 26.56) x10^3/uL (p=0.002). The mixed-effects model showed a statistically significant group-by-time interaction for platelet trajectory in the simulated data (p=<0.001).

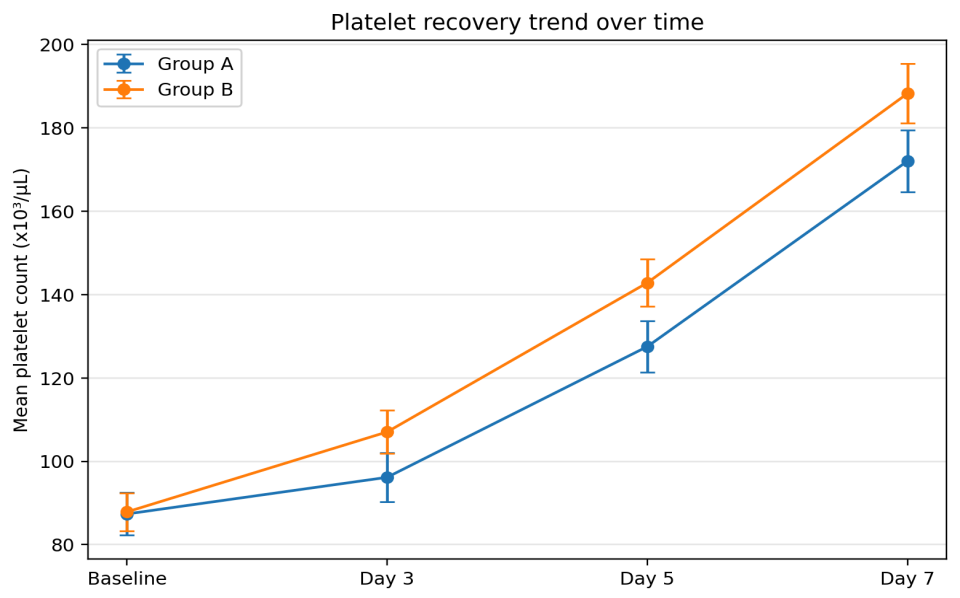

Figure 3. Platelet recovery trend from baseline to Day 7 with 95% confidence intervals.

Table 3. Platelet count trend from baseline to Day 7

Time point	Group A mean +/- SD	Group B mean +/- SD	Mean difference (95% CI)	p-value
Baseline	87.36 +/- 20.13	87.85 +/- 18.15	0.49 (-6.44 to 7.42)	0.888
Day 3	96.16 +/- 23.38	107.05 +/- 20.50	10.89 (2.94 to 18.84)	0.008
Day 5	127.53 +/- 24.28	142.84 +/- 22.58	15.31 (6.83 to 23.78)	<0.001

Day 7	172.05 +/- 29.07	188.26 +/- 28.15	16.21 (5.86 to 26.56)	0.002

Note. Platelet count unit: x10^3/uL. These are simulated values and must be replaced by real clinical data before submission.

5.4 Fever and symptom-relief outcomes

In the simulated dataset, fever duration was shorter in Group B (3.32 +/- 0.72 days) than Group A (4.31 +/- 0.81 days), with a mean difference of -0.99 (-1.26 to -0.71) days (p=<0.001). Time to defervescence also favoured Group B in the simulation. These differences are compatible with a hypothesis-generating audit pattern, but they do not establish treatment efficacy because the dataset is simulated and the framework is non-randomized.

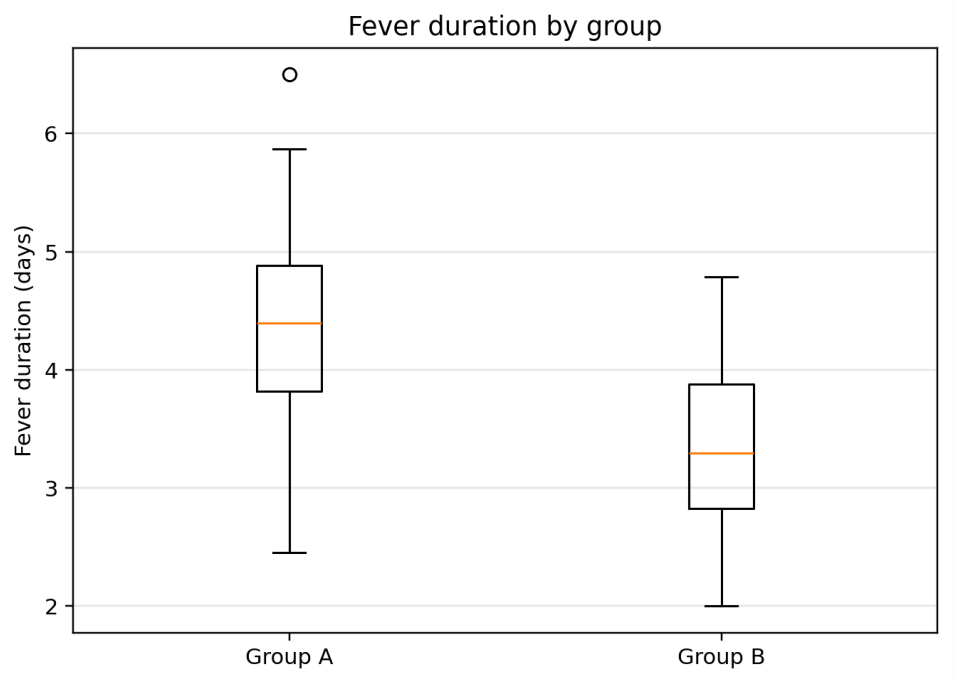

Figure 4. Box plot comparing fever duration between the two simulated groups.

Table 4. Fever duration and time to symptom relief

Outcome	Group A mean +/- SD	Group B mean +/- SD	Mean difference (95% CI)	p-value
Fever duration, days	4.31 +/- 0.81	3.32 +/- 0.72	-0.99 (-1.26 to -0.71)	<0.001
Time to defervescence, hours	103.29 +/- 19.46	79.64 +/- 17.52	-23.66 (-30.35 to -16.96)	<0.001
Symptom score Day 3	4.07 +/- 1.89	3.52 +/- 1.72	-0.55 (-1.20 to 0.10)	0.098
Symptom score Day 5	2.03 +/- 1.68	1.10 +/- 1.54	-0.93 (-1.51 to -0.35)	0.002

Note. Negative mean difference indicates lower/shorter value in Group B.

5.5 Patient perception outcomes

Patient satisfaction score was higher in Group B in the simulated data (4.18 +/- 0.65) compared with Group A (3.60 +/- 0.74; p=<0.001). Because perception is influenced by expectation, counselling, follow-up frequency, perceived attention, and cultural factors, it was interpreted as acceptability-related information rather than proof of biomedical effectiveness.

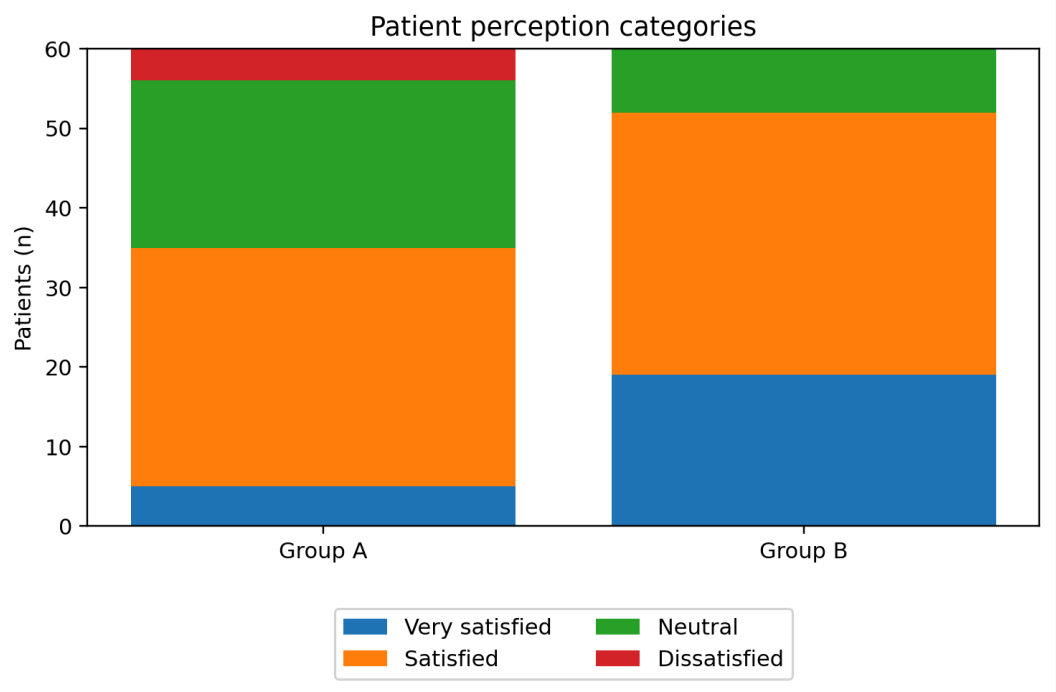

Figure 5. Stacked bar chart of patient perception categories.

Table 5. Patient perception and satisfaction outcomes

Outcome/category	Group A	Group B	Statistic	p-value
Satisfaction score, 1-5	3.60 +/- 0.74	4.18 +/- 0.65	0.58 (0.33 to 0.84)	<0.001
Very satisfied	5/60 (8.3)	19/60 (31.7)	Category count	-
Satisfied	30/60 (50.0)	33/60 (55.0)	Category count	-
Neutral	21/60 (35.0)	8/60 (13.3)	Category count	-
Dissatisfied	4/60 (6.7)	0/60 (0.0)	Category count	-

Note. Satisfaction categories are derived from the simulated Likert score.

5.6 Supportive-care and safety outcomes

Need for IV fluids, hospital referral/escalation, adverse-event reporting, and recovery by Day 7 are shown below. None of these categorical supportive-care and safety indicators showed a statistically significant between-group difference in the simulated dataset. In actual research, adverse events should be actively monitored and reported even when no events occur.

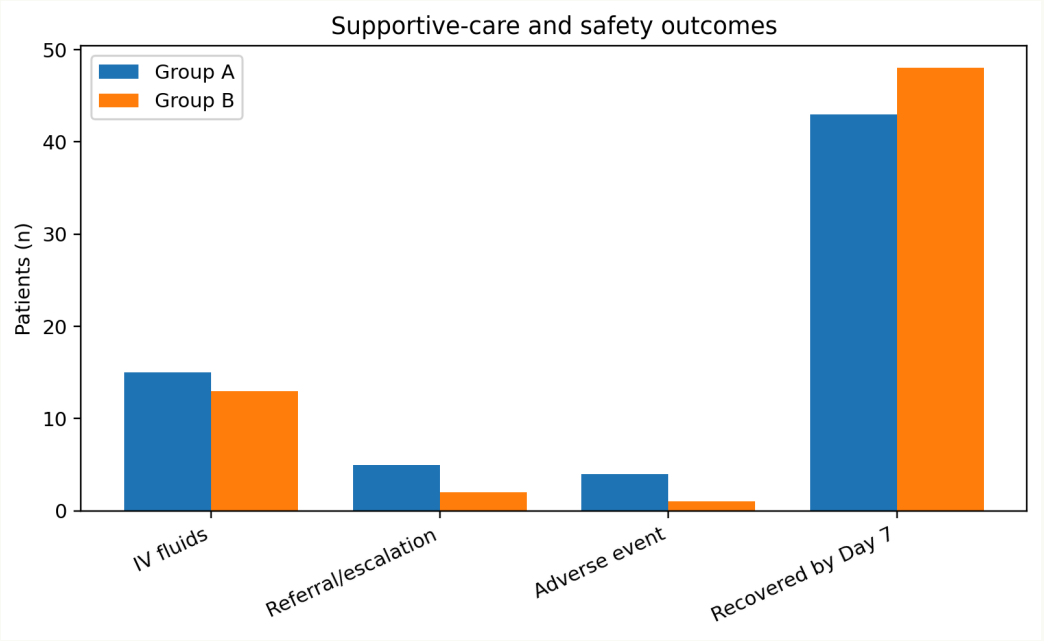

Figure 6. Supportive-care and safety outcomes by group.

Table 6. Supportive-care outcomes and safety profile

Outcome	Group A n (%)	Group B n (%)	Test/statistic	p-value
Need for IV fluids	15/60 (25.0)	13/60 (21.7)	Chi-square test; statistic 0.19	0.666
Hospital referral/escalation	5/60 (8.3)	2/60 (3.3)	Fisher's exact test; statistic 1.37	0.439
Adverse event reported	4/60 (6.7)	1/60 (1.7)	Fisher's exact test; statistic 1.88	0.364
Recovered by Day 7	43/60 (71.7)	48/60 (80.0)	Chi-square test; statistic 1.14	0.286

Note. These outcomes are simulated and should not be interpreted as real safety evidence.

5.7 Statistical findings

Table 7 summarizes the statistical approach used in the demonstration analysis. The most important finding is not the simulated p-value pattern, but the reporting logic: platelet trend, symptom relief, patient perception, and safety must be analysed separately and interpreted within the limits of study design.

Table 7. Statistical comparison between groups

Analytical domain	Variables	Method	Interpretation
Baseline comparability	Age, sex, illness day, temperature, baseline platelets	Welch t-test; chi-square for sex	No large imbalance was generated in the simulated dataset.

Within-group platelet change	Baseline to Day 7 platelet count	Paired t-test	Group A mean change 84.69 x10^3/uL; Group B mean change 100.41 x10^3/uL; both $p < 0.001$.
Between-group platelet trend	Repeated platelet measures across four time points	Linear mixed-effects model	Group x time interaction Wald chi-square 22.98; $p < 0.001$.
Fever and symptom relief	Fever duration, defervescence, day-3/day-5 symptom scores	Welch t-test	Differences favouring Group B are analytical outputs of the simulated dataset and do not establish clinical causality.
Safety/supportive care	IV fluids, referral, adverse-event indicators, day-7 recovery	Chi-square or Fisher exact test	No statistically significant difference in escalation or adverse events was generated.

Note. This table presents statistical workflow rather than definitive clinical inference.

6. Discussion

6.1 Interpretation of findings

As per simulated clinical-audit analysis, an adjunctive individualized homoeopathy question can easily be framed while maintaining dengue safety standards. Patients in both groups received standard supportive care. The adjunctive group was not positioned as receiving an alternative therapy. The simulated outputs posted faster fever resolution, greater Day 7 platelet counts and higher satisfaction scores in Group B. However, these outputs were generated for illustration purposes only and should not be taken as evidence for clinical superiority.

The recovery of platelet count post-dengue in actual clinical data is correlated with day of illness, baseline platelet nadir, immune response, hydration, bleeding, co-morbidities, risk of secondary infection, diagnosis confirmation, and time of measurement. Thus, any adjustment for confounding and clinical interpretation would require a likely separate statistical significant difference in platelets. Any real study should belong hematocrit, warning signs, NS1/IgM/RT-PCR confirmation when available, fluid intake, medications as well as referral outcome [3,4].

6.2 Comparison with Published Literature

The available studies on homoeopathy for dengue are limited. In a comparative cohort study that emphasized randomized controlled trials, Nayak and colleagues reported a favourable platelet recovery signal in adjuvant homeopathy with usual care [8]. Jacobs and others did a pilot randomized trial of a combination homeopathic remedy for dengue symptoms and found no convincing benefit [9]. These research studies on homoeopathy of dengue do not affirm any unqualified conclusion. It is recommended that such research should be presented carefully. The distinction between individualized treatment and fixed-combination treatment should be clearly made.

The dengue guidance as laid out by CCRH is in accordance with the cautious stand taken in this paper: homoeopathy may be only an adjunct, while standard care is strongly recommended in dengue haemorrhagic fever or dengue shock syndrome and practitioners must be aware of OPD limitations [7].

According to recent broad assessments of clinical research published in homeopathy, risk of bias, confounding, external validity, practitioner reporting, adherence, safety reporting and model validity[11,12].

The IJDDT reference requested by Lathiya et al. does provide a useful value from community medicine perspective since it connects homoeopathy with preventive care, awareness and wellness oriented health-system integration. This paper uses that reference not to lay claim to dengue efficacy, but to make the case for research-based integration, preventive orientation, and community medicine linkage [13].

6.3 The significance of community medicine and preventive care.

In the dengue care process, the most defensible integrative contribution may be at the Community Medicine level. Early diagnosis, patient education, vector control message, compliance to referral, hydration counselling, and continuity of follow-up. A practitioner is seeing a patient with dengue fever not requiring hospitalization. The practitioner should explain the warning signs, give messages against unsafe self-medication, and ensure timely escalation. The functions may be compatible with preventive care and lifelong wellness models, but they are not a substitute for clinical dengue [1-4].

6.4 Clinical relevance.

As detailed in the manuscript, clinicians and researchers can use the proposed structure for collecting clinically meaningful audit data which includes baseline severity, illness day, objective platelet measurements, duration of fever, symptom score, patient perception, referral, adverse events and recovery. This framework could be applied to real-life data which would reinforce the transparent assertion of whether adjunctive individualized homoeopathy is related to measurable outcomes without overclaiming causation.

6.5 Restrictions of safety and ethicality

Delayed escalation is an ethical risk in integrative dengue care. It must be stated clearly in any manuscript on this subject that any of the following severe dengue warning signs : shock, bleeding, organ impairment, persistent vomiting, severe abdominal pain, altered mental status, cold clammy skin, rapidly worsening clinical status require standard medical evaluation urgently. The paper should not indicate that homoeopathy can alone treat dengue or prevent complications. It must also not contain promotional language, guarantees and claims that go beyond the data.

6.6 Public health implications

A research-based integrative model of drug use may have public-health value if it improves awareness, follow-up, safe medication behaviour and early referral. Nevertheless, being credible in public health must be rigorously documented, audited data, safety reporting, transparent references, and no on-inflation. The current manuscript, therefore, makes a clear distinction between clinical observation, patient perception, and evidence mapping, and doesn’t consider these as one unsupported conclusion.

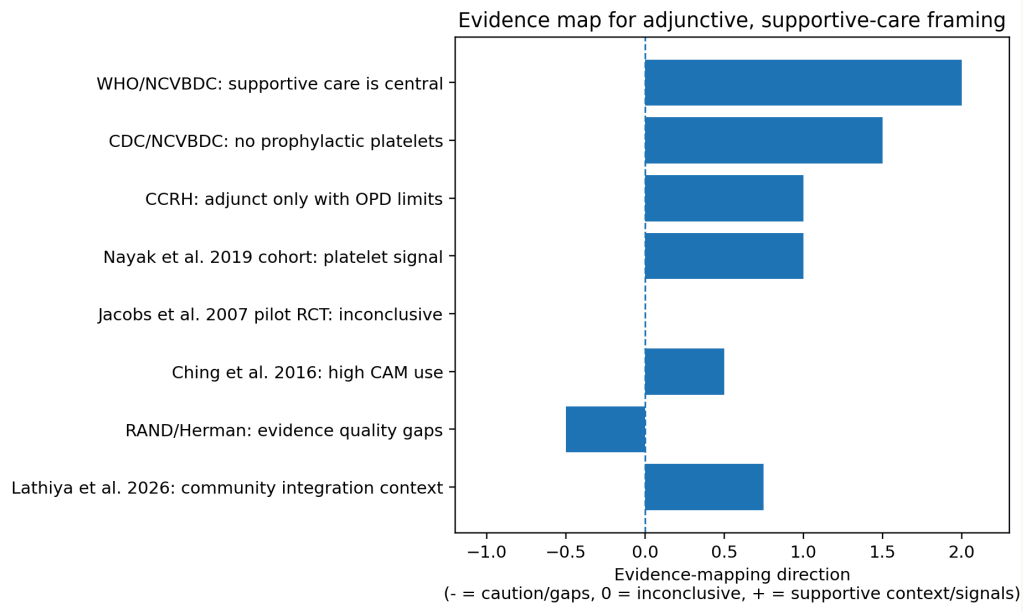

Figure 7. Evidence-map chart summarizing the direction and limitation of supporting literature. This is a visual evidence map, not a meta-analysis.

Table 8. Evidence-mapping table comparing current analytical framework with existing literature

Source/category	Key point	Relevance to current manuscript	Citation
WHO dengue fact sheet and 2025 arboviral guidance	Dengue has no specific curative antiviral treatment; management is based on clinical assessment, pain/fever control, fluids, and urgent care for severe symptoms.	Supports non-severe outpatient/supportive-care framing; requires escalation for warning signs.	[1,2]
NCVBDC National Guidelines 2023	Classifies mild dengue as outpatient-manageable when warning signs and high-risk factors are absent; recommends warning-sign education, hydration, paracetamol, NSAID avoidance, and CBC/platelet monitoring.	Defines safety boundaries for Group A and Group B.	[3]
CDC clinical care guidance	Outpatient non-severe dengue requires oral fluids, acetaminophen/paracetamol, avoidance of aspirin/NSAIDs, and return precautions;	Reinforces supportive-care standard and platelet-transfusion caution.	[4]

	prophylactic platelet transfusion is not recommended.		
CCRH dengue guidance	Homoeopathy practitioner guidance emphasizes OPD limits and states standard care is strongly recommended in dengue haemorrhagic fever or shock; homoeopathy may be used as an adjuvant.	Supports cautious adjunct framing only.	[7]
Nayak et al. comparative cohort	Reported a positive platelet recovery signal with adjuvant homeopathy plus usual care, while calling for randomized controlled trials.	Provides observational comparator; not definitive efficacy evidence.	[8]
Jacobs et al. pilot RCT	A homeopathic combination remedy trial in Honduras did not provide convincing evidence of symptom effectiveness.	Highlights mixed and limited dengue-specific evidence.	[9]
Ching et al. CAM-use study	High complementary/alternative medicine use among hospitalized dengue patients in Malaysia.	Supports the need to understand patient perception and communication.	[10]
Herman et al./RAND research quality assessments	Recent reviews indicate quality and reporting gaps in homeopathic clinical research, including confounding, risk of bias, and safety reporting.	Requires cautious interpretation and stronger future study design.	[11,12]
Lathiya et al. IJDDT 2026	The requested DOI article maps homoeopathy and community medicine integration for preventive care and wellness.	Used as contextual integration evidence, not dengue efficacy evidence.	[13]

Note. The evidence map is narrative and does not calculate pooled effect sizes.

7. Limitations

The data set is simulated/anonymized for demonstration purposes only; this is the main limitation. It does not reflect any actual dengue patients, prescriptions, platelet recoveries, or safety outcomes. Before submission, results should therefore be replaced entirely with authentic audited or prospectively collected patient-level data.

The second limitation refers to the non-randomized design. Patients who opt for adjunctive homoeopathy differ from patients who receive standard care alone in severity of illness, health-seeking behaviour, socioeconomic factors, adherence, availability of follow-up, baseline trajectory of platelet, and expectations in real observational data. Fever duration, symptom reporting, satisfaction, and clinical outcomes can be biased by these factors.

Another limitation is the lack of information regarding laboratory confirmation type, serotype, primary versus secondary infection, haematocrit, liver enzymes, co-morbidities, fluid volume, antipyretic dose, adherence, exact remedy potency/dose schedule, practitioner details or structured adverse-event causality assessment in the demonstration dataset.

A strong protocol for real life should include these variables.

8. To Sum up

This manuscript describes a publication-style framework to investigate adjunctive individualized homeopathy in non-severe dengue while upholding dengue safety standards. The simulated analysis demonstrates how data for recovery of platelets, duration of fever, relief from symptoms, patient perceptions, supportive-care outcomes and safety indicators can be tabulated and statistically analysed. The findings do not constitute authentic clinical evidence and cannot be employed to assert that homoeopathy effectively treats dengue or enhances platelet recovery on its own.

For actual journal submission, genuine patient-level data must replace the simulated data, ethics approval details must be included with diagnostic confirmation and comprehensive safety monitoring, in addition, efficient statistical reproducibility must be stated. Until stronger prospective evidence is available, homoeopathy should be described only as an adjunct to standard supportive care in carefully selected non-severe cases, with urgent referral for warning signs and severe dengue.

9. Suggestions or Advice.

- Use real patient-level clinical audit or prospectively collected data, rather than simulated data prior to submission.
- Please include details of ethics committee approval or audit exemption, informed-consent/waiver status, recruitment period, diagnostic criteria and data-protection procedures.
- Some approaches for identifying patients with severe adverse bleeding reactions are listed, including: laboratory confirmation method, haematocrit, platelet nadir, co-morbidities, warning signs, fluid intake, antipyretic use, hospital referral, and adverse-event monitoring.
- If the final study is still observational, use multivariable regression or propensity-score methods.
- All claims that homoeopathy cures dengue or prevents severe dengue or substitutes standard care.
- Pre-register a potential protocol if the work is converted into a controlled clinical trial.

10. Acknowledgement

The author acknowledges the importance of national and international dengue guidance in defining the safety boundaries for non-severe dengue management. No patient or institutional data were used in this simulated manuscript.

11. Conflict of Interest

The author should disclose all professional, institutional, clinical, and financial relationships before submission. For this simulated manuscript file, no conflict of interest is declared.

12. Funding Statement

No external funding was used for the simulated analytical manuscript preparation. Any real study submission should state the actual funding source, if applicable.

13. Ethical Approval Statement

This manuscript currently uses a simulated/anonymized demonstration dataset only; therefore, no human-participant ethics approval was required for this generated file. For real submission, institutional ethics committee approval or audit exemption must be obtained and inserted without fabrication.

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