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TUBERCULOSIS AND TUBERCULAR MIASM: AN INTEGRATIVE REVIEW FROM MODERN AND HOMOEOPATHIC PERSPECTIVES

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ABSTRACT

Tuberculosis (TB) continues to be a major infectious disease affecting global public health despite substantial progress in preventive, diagnostic, and therapeutic interventions. It is primarily caused by *Mycobacterium tuberculosis* and most commonly affects the lungs, although multiple organ systems may also be involved. ¹ Tuberculosis continues to remain a major burden in developing countries, especially India, where strengthened disease surveillance, early diagnosis, and standardize treatment strategies have been emphasized through national control programs. ^{2,3}

In homoeopathic philosophy, tuberculosis is also interpreted through the concept of the tubercular miasm, a constitutional state characterized by hereditary susceptibility, recurrent infections, emotional sensitivity, tissue destruction, and constitutional weakness.^{7,12} Classical homoeopathic stalwarts including Hahnemann, J. H. Allen, James Tyler Kent, and Margaret Tyler contributed significantly to understanding the constitutional manifestations associated with tubercular susceptibility.⁷⁻¹¹

The present review aims to critically evaluate tuberculosis from both contemporary medical and homoeopathic viewpoints with special emphasis on tubercular miasm and its relevance in homoeopathic practice. Information for this review was collected from standard medical textbooks, national tuberculosis guidelines, reports of international health organizations, and classical homoeopathic literature.^{1,15} Epidemiological patterns, etiology, clinical manifestations, diagnosis, treatment strategies, preventive approaches, and national tuberculosis elimination initiatives were reviewed alongside the constitutional interpretation of tubercular miasm.^{1,2,5} The review highlights that while modern medicine focuses primarily on microbiological diagnosis and evidence-based treatment protocols, homoeopathic philosophy contributes a constitutional understanding of susceptibility and individualized patient assessment. A combined conceptual understanding may support broader clinical interpretation and holistic patient-centered care.^{1,7}

Keywords: Tuberculosis, Tubercular Miasm, Homoeopathy, Constitutional Remedy, *Mycobacterium tuberculosis*, Tuberculinum, NTEP.

1. Introduction

Tuberculosis (TB) remains one of the oldest yet most significant communicable diseases affecting global populations despite substantial medical advancement. It is caused predominantly by *Mycobacterium tuberculosis*, an acid-fast bacillus that primarily affects pulmonary tissues but may also involve extra-pulmonary organs including lymph nodes, bones, meninges, kidneys, gastrointestinal organs, and skin.^{1,4} Transmission generally occurs through inhalation of infectious droplets released by infected individuals during coughing, sneezing, or speaking.¹ Despite being preventable and curable, tuberculosis continues to impose a major burden on healthcare systems worldwide, particularly in low- and middle-income countries. According to international health estimates, millions of individuals continue to develop disease annually, with socioeconomic factors such as poverty, malnutrition, overcrowding, smoking, alcoholism, HIV infection, diabetes mellitus, and immunosuppression significantly contributing to disease progression and susceptibility.^{1,4,5} India remains among the countries carrying the highest burden of tuberculosis globally and has implemented comprehensive public health measures through the National Tuberculosis Elimination Programme (NTEP), which focuses on early diagnosis, free treatment services, nutritional support, and digital surveillance systems to reduce disease incidence and mortality.^{2,3} From the homoeopathic perspective, tuberculosis extends beyond an infectious disease process and may also be interpreted constitutionally through the concept of tubercular miasm. Although Samuel

Hahnemann described chronic diseases primarily under the categories of psora, sycosis, and syphilis, later homoeopathic scholars such as J. H. Allen, James Tyler Kent, and Margaret Tyler elaborated the concept of tubercular susceptibility as a mixed miasmatic state characterized by constitutional weakness, recurrent infections, emotional sensitivity, tissue destruction, and heightened reactivity.⁷⁻¹²

The constitutional interpretation of tubercular miasm may help homoeopathic physicians understand hereditary predisposition, recurrent respiratory susceptibility, and individualized constitutional patterns. Therefore, the present review aims to examine tuberculosis comprehensively from both biomedical and homoeopathic viewpoints while emphasizing the significance of tubercular miasm in homoeopathic philosophy and therapeutics.^{1,7}

2. AIM

To critically review tuberculosis from modern medical and homoeopathic perspectives with special emphasis on the constitutional concept, clinical characteristics, and therapeutic significance of tubercular miasm in homoeopathic practice.

3. OBJECTIVES

1. To study the epidemiology, etiology, classification, and clinical manifestations of tuberculosis.^{1,5}
2. To evaluate currently available diagnostic methods and therapeutic

strategies for tuberculosis, including drug-resistant tuberculosis.^{1,2,6}

3. To assess the role of national tuberculosis prevention and elimination programs in disease control and public health management.^{2,3}
4. To understand the historical development and philosophical basis of tubercular miasm according to classical homoeopathic stalwarts.^{7,12}

4. MATERIALS AND METHODS

The present study was conducted using a narrative review methodology to collect and synthesize relevant information related to tuberculosis and tubercular miasm from both biomedical and homoeopathic perspectives. Information was obtained from standard medical textbooks, World Health Organization (WHO) reports, national tuberculosis guidelines, government health portals, peer-reviewed scientific literature, and recognized homoeopathic philosophical and materia medica texts.¹

The literature search focused on epidemiological patterns, etiology, classification, disease manifestations, investigations, diagnostic approaches, treatment strategies, preventive interventions, multidrug-resistant tuberculosis, and national elimination programs.¹⁻⁶ Simultaneously, classical homoeopathic texts were reviewed to understand the philosophical evolution, constitutional characteristics, clinical expressions, and therapeutic significance of tubercular miasm.⁷

5. EPIDEMIOLOGY

Global Epidemiology

Tuberculosis (TB) continues to represent a major public health challenge worldwide despite improvements in diagnostic facilities, antimicrobial therapy, and preventive interventions. It remains one of the leading

infectious causes of morbidity and mortality, particularly in low- and middle-income countries where socioeconomic disparities significantly influence disease transmission and treatment outcomes.¹

According to global health estimates, millions of individuals continue to develop active tuberculosis annually, making the disease a persistent healthcare burden despite being preventable and curable.¹ Factors such as poverty, overcrowding, undernutrition, inadequate sanitation, poor access to healthcare services, and delayed diagnosis substantially contribute to increased disease prevalence.^{1,5}

Certain medical and lifestyle-related conditions are also recognized as important contributors to disease susceptibility and progression. These include:

- Human Immunodeficiency Virus (HIV) infection
- Diabetes mellitus
- Malnutrition
- Smoking
- Alcohol dependence
- Immunosuppressive disorders
- Chronic systemic illnesses^{1,4,5}

The increasing prevalence of multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) continues to pose considerable challenges to disease control programs due to prolonged treatment duration, drug toxicity, financial burden, and treatment non-adherence.^{1,2}

Epidemiology of Tuberculosis in India

India continues to contribute a significant proportion of the global tuberculosis burden and remains one of the highest TB-burden countries worldwide.^{1,2} Multiple determinants such as population density, socioeconomic inequalities, migration, nutritional deficiencies, overcrowded living conditions, and inadequate healthcare

access contribute substantially to disease prevalence.^{2,5}

Tuberculosis prevalence is comparatively higher among:

- Urban slum populations
- Tribal communities
- HIV-positive individuals
- Malnourished populations
- Diabetic patients
- Immunocompromised individuals^{1,2,5}

To strengthen disease prevention and management, the Government of India implemented the National Tuberculosis Elimination Programme (NTEP), aiming to reduce incidence, mortality, and catastrophic expenditure associated with tuberculosis through patient-centered public health interventions.^{2,3}

Important Epidemiological Considerations

Tuberculosis infection does not invariably result in active disease in all exposed individuals. Many infected persons remain asymptomatic and non-infectious, a condition commonly referred to as latent tuberculosis infection (LTBI).¹ However, progression to active disease may occur when host immunity declines or predisposing risk factors are present.^{1,4}

Certain population groups remain particularly vulnerable to disease progression, including:

- Infants and young children
- Elderly individuals
- HIV-positive patients
- Diabetic patients
- Individuals with compromised immunity
- Malnourished populations^{1,4,5}

Recognition of epidemiological risk factors is essential for early diagnosis, prevention strategies, and effective disease surveillance.^{1,2}

6. ETIOLOGY

Tuberculosis is primarily caused by *Mycobacterium tuberculosis*, a slow-growing acid-fast bacillus possessing the ability to survive within host macrophages for prolonged durations.^{1,6} Although pulmonary involvement is most common, hematogenous and lymphatic dissemination may result in disease affecting several organ systems.¹

The *Mycobacterium tuberculosis* complex consists of several related organisms including:

- *Mycobacterium tuberculosis*
- *Mycobacterium bovis*
- *Mycobacterium africanum*
- *Mycobacterium microti*^{1,6}

Among these, *Mycobacterium tuberculosis* remains the predominant pathogen responsible for human infection.¹

Mode of Transmission

Tuberculosis spreads primarily through airborne transmission. Infectious droplets containing tubercular bacilli are expelled when affected individuals cough, sneeze, laugh, or speak.¹ Prolonged close contact with infectious patients significantly increases the risk of transmission.

Following inhalation, bacilli may remain dormant for extended periods, leading to latent tuberculosis infection or may progress to active disease depending upon immune competence and associated risk factors.^{1,4}

Predisposing Factors

Several conditions increase the likelihood of disease activation:

- HIV infection
- Diabetes mellitus
- Smoking
- Alcoholism
- Malnutrition
- Overcrowded living conditions
- Immunosuppressive therapy
- Chronic illnesses^{1,4,5}

7. CLASSIFICATION OF TUBERCULOSIS

Tuberculosis may be classified according to anatomical site, disease activity, and drug resistance patterns.^{1,2}

Based on Anatomical Site

1. Pulmonary Tuberculosis

Pulmonary tuberculosis involves lung parenchyma and represents the most prevalent and infectious form of disease. Common manifestations include persistent cough, sputum production, chest discomfort, fever, weight loss, and hemoptysis.^{1,4}

2. Extra-Pulmonary Tuberculosis

Extra-pulmonary tuberculosis affects organs other than the lungs and may involve:

- Lymph nodes
- Pleura
- Bones and joints
- Central nervous system
- Abdomen
- Genitourinary system
- Skin^{1,4,6}

Clinical manifestations vary depending upon the organ involved and often require specialized investigations for confirmation.¹

Based on Disease Activity

1. Latent Tuberculosis Infection (LTBI)

Latent tuberculosis refers to a state in which an individual harbors *Mycobacterium tuberculosis* without clinical symptoms or infectivity. Such individuals are usually asymptomatic but may demonstrate positive immunological tests indicating prior exposure.¹

2. Active Tuberculosis Disease

Active tuberculosis develops when bacilli proliferate and produce symptomatic disease. Patients may present with constitutional

symptoms and contribute significantly to disease transmission, particularly in pulmonary tuberculosis.^{1,4}

Based on Drug Resistance

1. Drug-Sensitive Tuberculosis

Drug-sensitive tuberculosis responds effectively to standard first-line antitubercular treatment when therapeutic regimens are appropriately followed.^{2,6}

2. Drug-Resistant Tuberculosis

Drug-resistant tuberculosis develops when bacilli become resistant to commonly administered antitubercular medications due to incomplete treatment, irregular medication intake, poor compliance, or inappropriate therapeutic practices.^{1,2}

Multidrug-Resistant Tuberculosis (MDR-TB):

MDR-TB demonstrates resistance to both rifampicin and isoniazid, considered the most effective first-line drugs.^{1,2}

Extensively Drug-Resistant Tuberculosis (XDR-TB):

XDR-TB demonstrates broader resistance patterns, resulting in greater therapeutic difficulty and poorer outcomes.¹

CLINICAL FEATURES OF TUBERCULOSIS

The clinical presentation of tuberculosis depends upon the site involved, severity of infection, immune status of the patient, and duration of disease. Symptoms frequently develop gradually, leading to delayed diagnosis and increased community transmission.^{1,4}

General Clinical Manifestations

Patients suffering from active tuberculosis commonly exhibit:

- Persistent cough lasting more than two weeks
- Sputum production, occasionally blood stained
- Chest pain or respiratory discomfort
- Progressive weight loss
- Generalized weakness and fatigue
- Evening rise of temperature
- Night sweats
- Reduced appetite and malaise^{1, 4}

Clinical Features of Extra-Pulmonary Tuberculosis

Tubercular Lymphadenitis

Tubercular lymphadenitis commonly presents with enlarged cervical lymph nodes, glandular swelling, matting of nodes, and occasionally cold abscess formation.^{1, 6}

Tubercular Meningitis

Neurological manifestations may include:

- Persistent headache
- Vomiting
- Neck rigidity
- Altered sensorium
- Convulsions
- Neurological deficits^{1, 4, 6}

Skeletal Tuberculosis

Involvement of bones and joints may result in:

- Chronic bone pain
- Spinal deformities
- Joint swelling
- Restricted movement^{1, 4}

Abdominal Tuberculosis

Common manifestations include:

- Abdominal pain
- Distension
- Altered bowel habits
- Ascites
- Constitutional weakness^{1, 4}

Recognition of these clinical manifestations is essential for early diagnosis, prevention of complications, and initiation of prompt therapeutic intervention.^{1, 2}

8. INVESTIGATIONS

The diagnosis of tuberculosis requires an integrated approach involving clinical evaluation, microbiological confirmation, molecular diagnostics, radiological investigations, and supportive laboratory findings. Early detection is essential for timely treatment initiation, prevention of complications, and interruption of disease transmission.^{1, 2}

1. Sputum Examination

Sputum examination remains one of the fundamental investigations in pulmonary tuberculosis and plays an important role in detecting infectivity.^{1, 6}

Ziehl–Neelsen Staining

Ziehl–Neelsen staining is commonly employed for the identification of acid-fast bacilli (AFB) in sputum samples. The presence of AFB supports the diagnosis of pulmonary tuberculosis.^{1, 6}

Fluorescent Microscopy

Fluorescent microscopy offers greater sensitivity compared with conventional staining methods and facilitates improved bacillary detection, especially in high-burden settings.^{2, 6}

2. Molecular Diagnostic Tests

Recent advancements in molecular diagnostics have significantly improved rapid tuberculosis detection and drug resistance screening.^{1, 2}

CBNAAT/GeneXpert

Cartridge-Based Nucleic Acid Amplification Test (CBNAAT) or GeneXpert is a rapid molecular diagnostic test capable of detecting *Mycobacterium tuberculosis* and rifampicin resistance within a short duration.^{1, 2}

TrueNat

TrueNat is a portable molecular diagnostic platform increasingly utilized in India for rapid

diagnosis, especially in peripheral and resource-limited healthcare settings.^{2,3}

3. Culture Techniques

Culture remains the gold standard for microbiological confirmation of tuberculosis and drug susceptibility assessment.^{1,6}

Lowenstein–Jensen Medium

This conventional culture medium facilitates mycobacterial growth but generally requires prolonged incubation periods for confirmation.⁶

Mycobacterial Growth Indicator Tube (MGIT)

MGIT culture systems provide relatively faster detection and assist in drug sensitivity testing.^{1,6}

4. Tuberculin Skin Test

The Mantoux or Tuberculin Skin Test (TST) assists in identifying exposure to tuberculosis infection and is particularly useful for screening latent tuberculosis infection among high-risk populations.¹

5. Radiological Evaluation

Chest X-Ray

Chest radiography serves as an important supportive diagnostic investigation in pulmonary tuberculosis. Frequently observed findings include:

- Upper lobe infiltrates
- Cavitory lesions
- Pulmonary fibrosis
- Pleural effusion
- Nodular infiltrations^{1,4,6}

6. Blood Investigations

Routine hematological investigations may provide supportive evidence of systemic inflammation. Common findings include:

- Elevated erythrocyte sedimentation rate (ESR)
- Mild anemia
- Altered complete blood count parameters^{1,6}

7. Histopathological Examination

Histopathology remains particularly valuable in extra-pulmonary tuberculosis and tissue-based diagnosis. Characteristic findings may include granulomatous inflammation, caseous necrosis, and Langhans giant cells.^{1,6}

9. DIAGNOSIS OF TUBERCULOSIS

The diagnosis of tuberculosis depends upon careful clinical assessment supported by microbiological, molecular, radiological, and laboratory investigations.¹ Early diagnosis is crucial for minimizing disease transmission, improving prognosis, and preventing complications.²

Current international recommendations advocate rapid molecular diagnostic methods as the preferred initial investigations for suspected tuberculosis cases. Molecular assays facilitate early detection of tubercular bacilli and identification of drug resistance, thereby allowing timely therapeutic intervention.^{1,2}

Additional investigations such as sputum microscopy, culture, chest radiography, tuberculin skin testing, and interferon gamma release assays (IGRA) may be utilized depending upon disease presentation and clinical suspicion.^{1,6}

Diagnosis of extra-pulmonary tuberculosis frequently presents greater challenges due to non-specific symptoms and difficulty in obtaining biological specimens. Therefore, an integrated diagnostic approach remains essential for confirmation.^{1,4}

MULTIDRUG-RESISTANT TUBERCULOSIS (MDR-TB)

Drug-resistant tuberculosis represents one of the most serious challenges in contemporary tuberculosis control. Resistance generally

develops because of inappropriate medication use, incomplete treatment courses, poor patient compliance, interrupted drug supply, or incorrect prescriptions.^{1,2}

Multidrug-resistant tuberculosis (MDR-TB) is defined as tuberculosis resistant to both rifampicin and isoniazid, the two principal first-line antitubercular medications.^{1,2} Patients suffering from MDR-TB often require prolonged treatment regimens involving second-line drugs, which may be associated with increased toxicity, financial burden, and reduced adherence.¹

In severe circumstances, extensively drug-resistant tuberculosis (XDR-TB) may emerge, significantly limiting treatment options and increasing morbidity.^{1,2} Therefore, bacteriological confirmation and drug susceptibility testing remain essential before initiating treatment for resistant tuberculosis.¹

Advances in treatment strategies have improved outcomes in resistant disease through shorter all-oral regimens aimed at reducing pill burden, improving compliance, and enhancing therapeutic success.^{1,2}

10. TREATMENT OF TUBERCULOSIS

Successful tuberculosis management requires early diagnosis, strict treatment adherence, adequate follow-up, and prevention of treatment interruption.^{2,6}

First-Line Antitubercular Drugs

First-line medications remain the cornerstone of treatment for drug-sensitive tuberculosis.^{2,6}

Bactericidal Drugs

These drugs actively destroy tubercular bacilli and include:

- Isoniazid (H)
- Rifampicin (R)

- Pyrazinamide (Z)
- Streptomycin (S)^{2,6}

Bacteriostatic Drugs

These medications inhibit bacterial multiplication and support effective treatment outcomes.

- Ethambutol (E)
- Thioacetazone^{2,6}

Standardized multidrug regimens are generally administered under national tuberculosis control programs to ensure compliance and minimize treatment failure.^{2,3}

Treatment of Drug-Resistant Tuberculosis

Drug-resistant tuberculosis requires specialized treatment protocols utilizing second-line drugs.^{1,2} Commonly used medications include:

- Bedaquiline
- Linezolid
- Delamanid
- Fluoroquinolones
- Cycloserine
- Ethionamide^{1,2}

Compared with drug-sensitive tuberculosis, resistant tuberculosis treatment is generally longer, more complex, and requires close monitoring for adverse effects and therapeutic response.^{1,2}

11. PREVENTION OF TUBERCULOSIS

Tuberculosis prevention requires a combination of public health measures, vaccination strategies, nutritional support, and early treatment interventions.^{1,2} Major preventive measures include:

- Early diagnosis and prompt treatment of infectious cases
- Bacillus Calmette–Guérin (BCG) vaccination during childhood

- Nutritional improvement and immunity enhancement
- Reduction of overcrowding and improvement of ventilation
- Health education regarding respiratory hygiene
- Screening of close contacts and high-risk populations^{1, 2, 5}

Effective preventive interventions contribute substantially to reducing disease transmission and improving treatment outcomes.¹

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME (NTEP)

India has implemented several organized tuberculosis control strategies to reduce disease burden and strengthen healthcare delivery.^{2, 3}

The National Tuberculosis Control Programme (NTCP), introduced in 1962, laid the foundation for structured tuberculosis management in India. Subsequently, short-course chemotherapy and expanded vaccination programs improved disease control.⁵

The Revised National Tuberculosis Control Programme (RNTCP) later strengthened tuberculosis management through standardized treatment, supervised therapy, and improved diagnostic accessibility.^{2, 3}

In 2020, RNTCP was renamed as the **National Tuberculosis Elimination Programme (NTEP)** with the objective of eliminating tuberculosis in India through comprehensive public health interventions.^{2, 3}

Objectives of NTEP

- Reduction in tuberculosis incidence
- Reduction in mortality
- Prevention of catastrophic healthcare expenditure
- Universal access to diagnosis and treatment^{2, 3}

Major Components of NTEP

1. Early Case Detection

- Active case finding
- Universal drug susceptibility testing²

2. Free Diagnostic Services

- CBNAAT testing
- TrueNat testing
- Sputum examination^{2, 3}

3. Free Treatment Services

- Daily fixed-dose combination therapy
- Drug-resistant TB management²

4. Nutritional Support

Nikshay Poshan Yojana provides financial assistance to tuberculosis patients to improve nutritional support during treatment.^{2, 3}

5. Digital Surveillance

The **Nikshay Portal** supports patient tracking, treatment monitoring, and surveillance activities.^{2, 3}

6. Community Participation

Programs such as **Pradhan Mantri TB Mukh Bharat Abhiyaan** encourage community participation in supporting tuberculosis patients and improving awareness.^{2, 3}

The strengthening of national tuberculosis initiatives has considerably improved treatment accessibility, surveillance, nutritional support, and disease management across India.^{2, 3}

12. TUBERCULAR MIASM IN HOMOEOPATHY

Introduction to Tubercular Miasm

The concept of tubercular miasm occupies an important position in homoeopathic philosophy and constitutional therapeutics. It is generally considered a mixed miasmatic state exhibiting characteristics predominantly related to psora and syphilis, although certain authors also

recognize sycotic influences.^{7,10} Tubercular miasm is commonly associated with hereditary susceptibility, recurrent infections, emotional excitability, tissue destruction, and constitutional weakness.^{7,12}

Although tuberculosis is recognized in modern medicine as an infectious disease caused by *Mycobacterium tuberculosis*, homoeopathic philosophy interprets disease expression not merely at the pathological level but also through constitutional predisposition and chronic miasmatic influences.^{7,8}

Historical Perspective of Tubercular Miasm

Samuel Hahnemann

Samuel Hahnemann primarily described chronic diseases under the categories of psora, sycosis, and syphilis. Although tubercular miasm was not explicitly recognized as a separate miasmatic classification, manifestations resembling tubercular tendencies were considered consequences of mixed chronic miasmatic influences.⁷

DEFINITION OF TUBERCULAR MIASM

Tubercular miasm may be defined as a constitutional predisposition characterized by recurrent infections hereditary weakness, hypersensitivity, tissue degeneration, physical exhaustion and emotional instability^{7,8,9,10,11,12}. It reflects an unstable constitutional state affecting both physical and psychological health dimensions.

CHARACTERISTICS OF TUBERCULAR MIASM

Feature	Description
Miasmatic Nature	Mixed psoric-syphilitic

Feature	Description
	state ^{7,10}
Pathological Tendency	Destructive and degenerative ⁷
Disease Progression	Rapid ⁹
Hereditary Influence	Markedly significant ¹⁰
Tissue Affinity	Lungs, glands, bones, respiratory organs ^{8,13}
Constitution	Thin, narrow-chested, delicate individuals ⁹

CONSTITUTIONAL FEATURES OF TUBERCULAR MIASM

Individuals demonstrating tubercular constitutions frequently exhibit distinctive physical and constitutional characteristics recognized in homoeopathic practice.^{8,9}

Physical Constitution

Commonly observed constitutional features include:

- Thin and lean body habitus
- Narrow chest formation
- Delicate physical build
- Weak stamina
- Easy fatigability
- Poor resistance to recurrent illness^{8,9}

Such individuals frequently exhibit increased susceptibility to recurrent respiratory illnesses and glandular disorders.^{9,13}

Physical Tendencies

Tubercular constitutions may commonly demonstrate:

- Recurrent upper respiratory tract infections
- Persistent cough tendency
- Enlarged cervical glands
- Night sweats
- Progressive emaciation
- Poor immunity
- Allergic susceptibility^{8, 10, 13}

MENTAL AND EMOTIONAL CHARACTERISTICS

Mental symptoms play an important role in constitutional homoeopathic assessment. Tubercular constitutions frequently demonstrate emotional sensitivity and persistent psychological restlessness.^{8, 9}

Common Mental Characteristics

- Restlessness and dissatisfaction
- Constant desire for movement or travel
- Anxiety about health
- Emotional instability
- Irritability and impulsiveness
- Rapid mood changes
- Heightened nervous sensitivity^{8, 9, 11}

Emotional Characteristics

Common emotional traits include:

- Artistic temperament
- Imaginative disposition
- Romantic tendencies
- Sensitivity to criticism
- Alternating enthusiasm and discouragement¹¹

CLINICAL FEATURES OF TUBERCULAR MIASM

General Features

Individuals with tubercular constitutions frequently present with:

- Generalized weakness
- Easy fatigue
- Low-grade fever
- Profuse perspiration, particularly at night
- Progressive emaciation^{8, 10}

Respiratory Features

Respiratory manifestations may include:

- Chronic cough
- Recurrent bronchitis
- Chest weakness
- Breathlessness
- Hemorrhagic tendency in susceptible individuals^{9, 13}

Glandular Features

Frequently encountered glandular manifestations include:

- Enlarged lymph nodes
- Chronic glandular swellings
- Scrofulous tendencies
- Cold abscess formation^{10, 13}

Bone and Joint Features

Some individuals may demonstrate:

- Bone pain
- Joint discomfort
- Weak skeletal development
- Spinal weakness or deformity^{8, 13}

IMPORTANT HOMOEOPATHIC REMEDIES IN TUBERCULAR MIASM

1. Tuberculinum

Tuberculinum is considered one of the principal remedies associated with tubercular constitutions and recurrent respiratory disorders.^{13, 16}

Constitutional Features

- Thin, delicate constitution
- Narrow chest
- Frequent infections
- Marked exhaustion¹³

Mental Features

- Dissatisfaction
- Irritability
- Desire to travel and change
- Restlessness⁶

Clinical Indications

- Recurrent respiratory infections
- Chronic bronchitis

- Enlarged glands
- Tubercular constitutional tendency¹³

2. Phosphorus

Phosphorus is frequently indicated in delicate, slender individuals with marked emotional sensitivity and respiratory weakness.^{9, 13}

Indications

- Pulmonary weakness
- Hemorrhagic tendency
- Emotional sensitivity
- Need for company¹³

3. Calcarea Phosphorica

Calcarea phosphorica is commonly suited to poorly nourished individuals with delayed growth and weak constitution.¹³

Indications

- Poor nutrition
- Weak bone development
- Enlarged glands
- Anemia¹³

4. Bacillinum

Bacillinum is traditionally considered in recurrent respiratory complaints and chronic bronchial weakness.¹³

Indications

- Persistent cough
- Recurrent chest infections
- Chronic catarrhal states¹³

5. Silicea

Silicea is often indicated in delicate individuals with weak immunity and recurrent suppuration.^{13, 14}

Indications

- Glandular enlargement
- Chronic suppuration
- Poor stamina^{13, 14}

6. Iodum

Iodum is frequently indicated in rapidly emaciating constitutions with glandular enlargement despite increased appetite.¹³

Indications

- Progressive emaciation
- Hypermetabolic constitutions
- Tubercular glandular involvement¹³

13. DISCUSSION

Tuberculosis remains a major communicable disease worldwide despite substantial progress in diagnosis, antimicrobial treatment, and public health interventions.^{1, 2} Socioeconomic determinants including poverty, overcrowding, malnutrition, smoking, alcoholism, HIV infection, diabetes mellitus, and poor healthcare accessibility continue to influence disease transmission and severity.^{1, 4, 5}

Modern medicine primarily interprets tuberculosis as an infectious disease caused by *Mycobacterium tuberculosis* and emphasizes microbiological confirmation, molecular diagnostics, standardized treatment regimens, and surveillance systems for disease control.^{1, 2, 6} Molecular technologies such as CBNAAT and GeneXpert have considerably strengthened early diagnosis and drug resistance detection, especially in multidrug-resistant tuberculosis.^{2, 3}

In contrast, homoeopathic philosophy emphasizes constitutional susceptibility and miasmatic predisposition through the concept of tubercular miasm.^{7, 12} Classical homoeopathic scholars recognized recurring constitutional tendencies characterized by physical weakness, recurrent respiratory infections, emotional excitability, and hereditary predisposition.^{8, 10}

Homoeopathic remedies such as Tuberculinum, Phosphorus, Calcarea phosphorica, Bacillinum, Silicea, and Iodum are traditionally selected according to constitutional totality rather than pathological diagnosis alone.^{9, 13} Although philosophical foundations differ considerably from conventional biomedical concepts, an integrated understanding of disease

susceptibility and constitutional variation may contribute to broader patient-centered interpretation.^{1,7}

14. CONCLUSION

Tuberculosis continues to remain a significant global health concern requiring effective diagnosis, preventive measures, treatment adherence, and strengthened public health strategies.^{1,2} Despite major advances in diagnostics and therapeutic interventions, disease burden remains high in many developing countries.^{1,5}

The concept of tubercular miasm in homoeopathy provides a constitutional framework for understanding hereditary susceptibility, recurrent respiratory tendencies, emotional sensitivity, and chronic constitutional weakness.^{7,12} Classical homoeopathic scholars emphasized individualized constitutional prescribing for susceptible individuals.^{8,13}

The present review highlights the importance of examining tuberculosis through both biomedical and homoeopathic perspectives to broaden understanding regarding disease susceptibility and constitutional tendencies. While modern medicine provides evidence-based diagnosis and treatment, homoeopathic interpretation may contribute toward individualized constitutional understanding and holistic patient care.^{1,7}

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16. CONFLICT OF INTEREST

The authors declare that there is no conflict of interest related to this study and no financial assistance or external funding was received for the preparation of this manuscript.

17. REFERENCES

1. World Health Organization. Tuberculosis [Internet]. Geneva: World Health Organization; 2026 [cited 2026 May 19]. Available from: <https://www.who.int>
2. Ministry of Health and Family Welfare. National Tuberculosis Elimination Programme (NTEP) Guidelines [Internet]. New Delhi: Government of India; 2025 [cited 2026 May 19]. Available from: <https://tbcindia.mohfw.gov.in>
3. Directorate General of Health Services. National Tuberculosis Elimination Programme [Internet]. New Delhi: Directorate General of Health Services; 2025 [cited 2026 May 19]. Available from: <https://dghs.mohfw.gov.in>
4. Mayo Clinic. Tuberculosis: Symptoms and causes [Internet]. Rochester (MN): Mayo Foundation for Medical Education and Research; 2025 [cited 2026 May 19]. Available from: <https://www.mayoclinic.org>
5. Park K. Park's Textbook of Preventive and Social Medicine. 27th ed. Jabalpur: Banarsidas Bhanot Publishers; 2023.
6. Ralston SH, editor. Davidson's Principles and Practice of Medicine. 24th ed. Edinburgh: Elsevier; 2022.
7. Hahnemann S. The Chronic Diseases: Their Peculiar Nature and Their Homoeopathic Cure. New Delhi: B. Jain Publishers; 2009.

8. Kent JT. Lectures on Homoeopathic Philosophy. New Delhi: B. Jain Publishers; 2004.
9. Kent JT. Lectures on Homoeopathic Materia Medica. New Delhi: B. Jain Publishers; 2003.
10. Allen JH. The Chronic Miasms: Psora and Pseudo-Psora. New Delhi: B. Jain Publishers; 1994.
11. Tyler ML. Hahnemann's Conception of Chronic Diseases. New Delhi: B. Jain Publishers; 2003.
12. Close S. The Genius of Homoeopathy. New Delhi: B. Jain Publishers; 2013.
13. Boericke W. Pocket Manual of Homoeopathic Materia Medica. New Delhi: B. Jain Publishers; 2007.
14. Clarke JH. A Dictionary of Practical Materia Medica. New Delhi: B. Jain Publishers; 1995.
15. Allen HC. Keynotes and Characteristics with Comparisons of Some of the Leading Remedies of the Materia Medica