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CASE REPORT

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Behavioural and functional improvement through homoeopathic integration in geriatric post-hospitalisation delirium and dementia Care: A case report

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ABSTRACT

Background: Post-hospitalisation delirium in older adults with pre-existing dementia and multimorbidity represents a clinically challenging condition associated with significant morbidity, functional decline, and caregiver burden. Standard pharmacological management of behavioural disturbances in this population is often limited by adverse drug effects and polypharmacy concerns. Homeopathic therapy has been sought by caregivers as an adjunctive approach; however, documented case evidence in this setting remains limited.

Case Presentation: A 90-year-old male with a 15-year history of severe dementia and Parkinson's disease, complicated by heart failure with preserved ejection fraction (HFpEF), severe pulmonary arterial hypertension, ischaemic heart disease, acute kidney injury, type 2 diabetes mellitus, hypertension, and hypothyroidism, presented with hyperactive delirium, intractable right lower limb pain, complete anorexia, insomnia, and marked agitation following emergency hospitalisation.

Intervention: Individualised homoeopathic treatment was initiated as an integrative adjunct to conventional palliative care. Remedies prescribed sequentially included Carbo vegetabilis 6X (dyspnoea and hypoxia), Bacopa monnieri 6X (dementia-associated agitation and cognitive decline), Magnesia phosphorica 6X (severe lower limb pain), and Kali phosphoricum 6C (insomnia).

Outcomes: Within two weeks of initiating homoeopathic treatment, agitation and delirium-associated combative behaviour resolved to a calm demeanour. Supplemental oxygen requirement reduced from continuous (24 hours/day) to fewer than two hours per day. Severe right lower limb pain was alleviated, and the patient regained the ability to sit, ambulate with assistance, and participate in assisted self-care activities. No further hospitalisation was required during the period of homoeopathic care. The patient died peacefully at home on 28th November 2025.

Conclusion: This case suggests that individualised homoeopathic therapy may serve as a useful adjunct in geriatric palliative care, contributing to improvements in behavioural disturbance, pain, respiratory symptom burden, and functional status in a patient with post-hospitalisation delirium superimposed on advanced dementia. Prospective documentation and controlled studies are warranted to evaluate efficacy and mechanism in this vulnerable population.

KEYWORDS

Geriatric care; Homoeopathy; Post-hospitalisation delirium; Dementia; Palliative care; Integrative medicine; Functional improvement; Caregiver support

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Introduction

Delirium is a neuropsychiatric syndrome characterised by acute-onset fluctuating disturbance in attention, awareness, and cognition, arising as a consequence of an underlying medical condition. It has been described as 'acute brain failure' and represents the final common pathway of diverse pathophysiological mechanisms, analogous to acute organ failure in other systems [1,2]. Delirium is common across healthcare settings, affecting approximately 20% of general medical inpatients, up to 62% of post-surgical patients, and 80–90% of patients in palliative or intensive care units [3].

Older adults with pre-existing cognitive impairment are at disproportionately high risk of developing delirium during and after hospitalisation, with prolonged stay, accelerated cognitive decline, increased institutionalisation, higher mortality, and substantially reduced quality of life [4–6]. Post-discharge delirium goes unrecognised and undertreated; only a few evidence-based non-pharmacological interventions are available in the home or community palliative care context [2].

Homoeopathic medicine has been used empirically in geriatric and palliative care settings as an adjunct for symptom management, with caregivers reporting benefit for agitation, pain, insomnia, and respiratory distress. However, peer-reviewed documentation of outcomes in this population remains sparse. This case report describes an elderly patient with severe multimorbidity and post-hospitalisation hyperactive delirium who demonstrated marked clinical improvement following the integration of individualised homoeopathic treatment alongside conventional palliative care.

Case Presentation

Patient background

Mr V.T.S. was a 90-year-old male with a long-standing history of severe dementia of approximately 15 years' duration and Parkinson's disease. His additional comorbidities included heart failure with preserved ejection fraction (HFpEF), severe pulmonary arterial hypertension (PAH), ischaemic heart disease (fully evolved anterior wall myocardial infarction),

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type 2 diabetes mellitus, systemic hypertension, hypothyroidism, and acute kidney injury. He was of short stature and appeared adequately nourished, though peripheral oedema was present.

Before the index admission, his dementia had severely impaired his daily activities for several years. In 2019, during a home visit at the age of 84, it was observed that he required step-by-step verbal instruction to perform basic tasks such as bathing and needed to be fed each spoonful of food, as he would otherwise stop mid-task. He had been receiving Bacopa monnieri (an Ayurvedic preparation, Brahmi) for dementia-related agitation, with reported benefit, before homoeopathic consultation.

Table 1. Patient information and diagnosis.

Category	Details
Patient	Mr. Venkatesan T.
Age / Sex	90 years / Male
Date of Admission	14-Mar-25
Time of Admission	3:35 AM (Emergency)
Primary Diagnoses	Acute Decompensation of Heart Failure – HFpEF / Severe PAH
—	Inferior-wall MI (Fully Evolved AWMI) – Adequate LV Function, EF 55%
—	Acute Kidney Injury
Co-morbidities	Type 2 Diabetes Mellitus
—	Systemic Hypertension
—	Hypothyroidism
—	Dementia / Parkinson's Disease
Presenting Complaints	Breathlessness, pedal edema, decreased urine output (past 1 day)
Clinical Assessment	Acute coronary ischemia-induced acute LVF
Management Plan	Admitted to CCU for further management
Past History of IHD	None

Index hospitalisation

On 14 March 2025, the patient was admitted as an emergency to the coronary care unit with a two-day history of worsening breathlessness, bilateral pedal oedema, and oliguria. He was diagnosed with acute decompensated heart failure in the context of acute coronary ischaemia-induced left ventricular failure (EF 55%), severe PAH, and acute kidney injury. He required intensive inpatient management and was subsequently discharged but was re-hospitalised within the same month for a second acute episode with oxygen saturation (SpO_2) recorded at 85%.

Table 2. Echocardiogram summary (14.03.25).

Parameters	Finding
LV Hypertrophy	Present (Concentric)
LV Systolic Function	Adequate
LV Ejection Fraction	~55%
Mitral Regurgitation	Trivial
Aortic Valve	Sclerotic / Trivial AR / No AS
Tricuspid Regurgitation	Grade II
Right Atrium / Right Ventricle	Mildly Dilated
Pulmonary Artery Hypertension	Severe (PASP / RVSP: 72 mmHg)
RV Function	Normal (TAPSE ~18 mm)
PA & Branches	Normal Sized
IVC	Normal Size / Collapsing
Pericardial Effusion	Trace
LV Thrombus	Nil

Table 3. ECHO – doppler measurements (14.03.25).

Valve	Velocity (m/sec)	Gradient (mmHg)
Mitral Valve	Raised	—
Aortic Valve	1.1	—
Pulmonary Valve	0.5	5
Tricuspid Valve	4.2	—
RVSP	**—**	72 mmHg

Table 4. ECHO – measurements & volumes (14.03.25).

Parameter	Value	Parameter	Value
Aorta	3.0 cm	Left Atrium	3.5 cm
IVS Diastole	1.1 cm	PW Diastole	1.4 cm
IVS Systole	1.7 cm	PW Systole	1.6 cm
LVDd	4.4 cm	LVDs	3.1 cm (approx)
RVDd	3.2 cm	Left Atrial Volume	22 ml
EDV	86 ml	ESV	—
LV Ejection Fraction	55%	—	—

Table 5. ECHO – morphology (14.03.25).

Structure	Finding
Left Atrium	Normal
Right Atrium	Dilated
Aorta	Normal
Right Ventricle	Dilated
Left Ventricle	Concentric LVH
Mitral Valve	AML and PML Normal
Tricuspid Valve	Normal
Pulmonary Valve	Normal
Aortic Valve	Sclerotic
Pulmonary Artery	Dilated
Aortic Arch	Normal
Inter-Atrial Septum	Intact
Inter-Ventricular Septum	Intact
LV Clot	Nil
LA / LAA Clot	Nil
Pericardium	Normal

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Table 5 (continued)

Structure	Finding
Regional Wall Motion	No Obvious Abnormality

Table 6. Laboratory results.

Test	14.03.25	16.03.25	Unit
Haemoglobin	14	—	g/dL
Urea	43.3	37.6	mg/dL
Creatinine	1.32	1.2	mg/dL
Sodium	134.6	135.3	mmol/L
Potassium	4.65	3.3	mmol/L
RBS	246	184	mg/dL
Uric Acid	3.95	5.65	—
Magnesium	2	72.6	—
Spot Urine Sodium (6:30 PM)	52.1	—	—
Urine Chloride	109	102	—
D-Dimer	3427.68	—	—
NT Pro-BNP	>25000	—	—

Table 7. Course in hospital.

Date / Event	Details
14.03.25 – Admission	Admitted to CCU
Treatment Initiated	NIV support, IV Lasix infusion, loading dose of Cloplet and Atorvastatin
Ongoing Management	Heart failure medications, anti-anginal therapy, fluid restriction
Progress	Patient symptoms improved
Counselling	MI, AKI, severe PAH, risk of fatal arrhythmias and sudden cardiac death explained to patient/family
16.03.25 – Step Down	NIV and IV Lasix infusion stopped; patient shifted to ward
16.03.25 ~9:30 PM	Patient developed SVT; reverted to sinus rhythm with IV Amiodarone (bolus)

Clinical Status at Homeopathic Assessment (3 April 2025)

On assessment at the patient's residence approximately three weeks after the initial discharge,

General

Bedridden in a semi-erect position, lying on the left side, grimacing with pain on contact.

Respiratory

Continuous supplemental oxygen requirement; SpO_2 85–93% on oxygen.

Pain

Severe right lower limb pain (right foot and knee), Visual Analogue Scale (VAS) rated 3+; patient screamed on any contact with the affected limb; unable to extend or flex the knee.

Cognitive and behavioural

Oriented only to name; non-verbal for purposeful communication; unable to retain recent memory; retained only distant childhood memories. Presented with hyperactive delirium characterised by marked agitation, combative behaviour towards caregivers, verbal abuse, and nocturnal hallucinations and delusions.

Table 8. Diagnostic criteria for delirium based on DSM-5 and Confusion Assessment Method (CAM) features.

Source of Criteria	Criterion / Feature	Diagnostic Criteria
DSM-5		Disturbance in attention and awareness
DSM-5		Disturbance develops acutely and tends to fluctuate in severity
DSM-5		At least one additional disturbance in cognition
DSM-5		Disturbances are not better explained by a preexisting dementia
DSM-5		Disturbances do not occur in the context of a severely reduced level of arousal or coma
DSM-5		Evidence of an underlying organic cause or causes
Confusion Assessment Method (CAM)	Feature 1	Acute change in mental status with a fluctuating course
Confusion Assessment Method (CAM)	Feature 2	Inattention
Confusion Assessment Method (CAM)	Feature 3	Disorganized thinking
Confusion Assessment Method (CAM)	Feature 4	Altered level of consciousness

Nutrition and Swallowing

Complete anorexia; actively refused oral feeding (pushed away porridge and caregivers); inability to swallow solids.

Sleep

Severely disrupted despite conventional sedative medication.

Functional status

Fully dependent on caregivers for all activities; unable to sit, stand, or transfer. Actively uncooperative with personal hygiene and nursing care, causing significant caregiver burden.

The clinical picture was consistent with hyperactive delirium superimposed on severe pre-existing dementia, compounded by multisystem medical decompensation. The patient's primary caregiver (his daughter) sought homeopathic consultation specifically for management of agitation, sleep disturbance, and non-cooperation with care, as these symptoms were inadequately controlled with existing medications.

His functional assessment on the FAST scale was 7D/E.

Functional assessment staging tool (FAST Scale)

- **No difficulty** either subjectively or objectively.
- **Complaints of forgetting the location of objects.** Subjective work difficulties.

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• **Decreased job functioning** evident to co-workers. Difficulty in traveling to new locations.Decreased organizational capacity. *

• **Decreased ability to perform complex tasks**, e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.

• **Requires assistance in choosing proper clothing** to wear for the day, season, or occasion, e.g., patient may wear the same clothing repeatedly, unless supervised.

• Improperly putting on clothes without assistance or prompting (e.g., may put street clothes on overnight clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.

• Unable to bathe properly (e.g., difficulty adjusting bathwater temperature) occasionally or more frequently over the past weeks.

• Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.

• Urinary incontinence occasionally or more frequently over the past weeks.

• Faecal incontinence occasionally or more frequently over the past weeks.

• Ability to speak is limited to approximately a half-dozen intelligible different words or fewer in the course of an average day or in the course of an intensive interview.

• Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).

• Ambulatory ability is lost (cannot walk without personal assistance).

• Cannot sit up without assistance.

• Loss of ability to smile.

• Loss of ability to hold head up independently.

Footnote

Scored primarily on the basis of information obtained from a knowledgeable informant.

Adapted from

Intervention

Homeopathic treatment was initiated on 3 April 2025 as an integrative adjunct to the patient's ongoing conventional palliative care, which included supplemental oxygen, antihypertensive, antidiabetic, and cardiac medications managed by his allopathic physician. Remedy selection was based on a holistic assessment of the patient's current symptom complex, incorporating his documented medical history and prior response to Bacopa monnieri.

Table 9. The following remedies were prescribed sequentially, administered in liquid form as tolerated.

Remedy	Potency / Frequency	Therapeutic Indication
Carbo vegetabilis	6X, as required	Dyspnoea, hypoxia, and impaired oxygenation
Bacopa monnieri	6X, daily (continued)	Dementia-associated agitation, behavioural disturbance, and cognitive decline; previously established with benefit
Magnesia phosphorica	6X, as required	Severe right lower limb pain with hypersensitivity to touch
Kali phosphoricum	6C, nightly	Insomnia and nervous exhaustion

All remedies were administered sequentially and titrated to symptomatic response. Ignatia amara 6C and Natrum muriaticum 6C were added subsequently to address grief-related emotional features observed during follow-up. From July 2025, Rumex crispus 6C, Coccus cacti 6C, and Strophanthus Q were introduced to address progressive cough and breathlessness associated with hydrothorax. Conventional palliative care, including nebuliser therapy (prescribed by his palliative physician), oral medications, and nursing support, was maintained throughout.

Outcomes

Clinical timeline

The following table summarises the key assessment points and corresponding clinical findings and interventions from 3 April to 28 November 2025.

Table 10. Clinical course, interventions, and outcomes documented during longitudinal palliative care follow-up.

Date	Clinical Findings	Intervention / Remedies
03-Apr-25	Bedridden; SpO_2 85–93% on continuous O_2; severe right leg pain (VAS 3+); hyperactive delirium with combative behaviour; complete anorexia; severe insomnia; unable to sit or stand.	*Carbo veg 6X; Bacopa monnieri 6X;* *Magnesia phos 6X; Kali phos 6C; Strophanthus O* (sequential administration).
07-Apr-25	Agitation significantly reduced; calmer demeanour. Sleep improved. SpO_2 stabilising. Right leg pain reduced; patient able to sit and accept porridge. Ambulating short distances to bathroom with assistance.	Regime continued. *Ignatia 6C* and *Natrum mur 6C* added for emotional features.
22-Apr-25	Sustained improvement. No agitation. Eating and sleeping better. Walking with support. Supplemental O_2 reduced to 1–2 hours/day (given only if SpO_2 < 90%); night-time use of ~3 hours for sleep.	Regimen maintained.
02-Jul-25	SpO_2 89–93% without continuous O_2. New onset productive cough; hydrothorax identified. Nebuliser commenced by palliative physician. No re-hospitalisation required.	*Rumex 6C; Coccus cacti 6C; StrophanthusQ* for cough and breathlessness added.

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Table 10 (continued)

Date	Clinical Findings	Intervention / Remedies
06-Sep-25	Sleep improved further. SpO_2 maintained. O_2 support near-absent. Cough present but controlled.	Regimen continued.
26-Nov-25	Acute deterioration: high fever, profuse sweating, severe cough (3+), SpO_2 fell to 42 then 88; unable to swallow. Treated with antibiotics for three days with partial improvement.	Supportive management; antibiotics by conventional physician.
28-Nov-25	Patient passed away peacefully at home.	No further intervention required.

Summary of outcomes

Behavioural outcomes

Hyperactive delirium with combative behaviour resolved within four days of commencing homeopathic treatment. The patient's demeanour transitioned from markedly agitated and uncooperative to calm and participatory. No further episodes of violent behaviour were documented. Fast scale from 7D improved to 5D/6 level with reasonable relief to his family members.

Pain

Severe right lower limb pain (VAS 3+) was substantially alleviated by the second follow-up visit. The patient could sit comfortably and ambulate short distances with assistance.

Respiratory status

Supplemental oxygen requirement reduced from continuous 24-hour use to fewer than two hours per day by 22 April 2025, with SpO_2 maintained at 89–93% on room air during intervening periods.

Nutrition and function

Oral intake improved; the patient accepted porridge and progressed to eating with caregiver assistance. Functional mobility improved from fully bedridden to ambulatory with support.

Hospitalisation

The patient had required two emergency hospitalisations in the month preceding homeopathic intervention. No further hospitalisation was required for the duration of homeopathic care (approximately eight months).

Sleep

Sleep initially improved with Kali phosphoricum 6C; however, long-term sleep consolidation was achieved primarily through conventional pharmacotherapy. Homeopathic contribution to sleep was considered partial.

Caregiver wellbeing

The patient's octogenarian wife and daughters, who served as primary caregivers, also received homeopathic treatment for anxiety, insomnia, and caregiver-related stress, with self-reported improvement.

Discussion

This case report describes clinically meaningful improvements in behavioural, functional, and respiratory domains in a 90-year-old patient with post-hospitalisation hyperactive delirium superimposed on advanced dementia, following the integration of individualised homeopathic treatment within a conventional palliative care framework.

Post-hospitalisation delirium in older adults with dementia represents a high-risk clinical scenario. Fick et al. demonstrated that delirium superimposed on dementia is independently associated with prolonged hospital stay and significantly worse clinical outcomes compared to delirium or dementia alone [6]. Tesfaye et al., in a recent systematic review and meta-analysis, confirmed that delirium after hospital discharge is associated with long-term cognitive and functional decline, higher rates of readmission, and increased mortality [5]. These findings underscore the importance of effective post-discharge management strategies for this population.

The hyperactive subtype of delirium, as observed in this patient, is characterised by agitation, combative behaviour, hallucinations, and sympathetic hyperactivation [1]. Pharmacological management of agitation in elderly patients with dementia is complicated by risks of over-sedation, falls, aspiration, and paradoxical worsening with benzodiazepines or antipsychotics. Non-pharmacological approaches are therefore increasingly recommended as the preferred first-line strategy [2].

In this case, Bacopa monnieri 6X appeared to contribute most directly to the resolution of agitation and behavioural disturbance. Bacopa monnieri (Brahmi) has established neuroprotective and anti-anxiety properties, with clinical trials supporting its use for cognitive function and anxiety reduction in older adults [7]. Bacopa monnieri functioning as a cognitive performance enhancer was demonstrated in a small (17-patient) randomized control trial published in 2014 [8].

Under generalities, bacopa drug randamosised proving produced 22 symptoms of that “Restless, changes position and moves about, aggravation at night (1,200C) (44,2)” were noted. Magnesia phosphorica 6X was associated with substantial pain relief, enabling the patient to tolerate physical contact, sit, and mobilise, changes that directly reduced agitation related to pain-provoked distress. Carbo vegetabilis 6X appeared to correlate with improvement in oxygenation and reduced supplemental oxygen dependence, though the concurrent stabilisation of cardiac and renal function by conventional management was a contributing factor, which was improved with the above-said drug [9].

The absence of further hospitalisation over eight months is a noteworthy finding, given that the patient had required two emergency admissions within the preceding month. While this observation is consistent with improved symptom control and caregiver capacity, it cannot be causally attributed to homoeopathic treatment, as Fick et al. noted that “Those with delirium had a 25% short-term mortality rate, increased length of stay, and poorer function at discharge” [6]. Although in the absence of a comparator group, the action of homoeopathy cannot be vindicated sufficiently. The patient's clinical trajectory progressing from fully bedridden and combative to ambulatory and cooperative represented a meaningful improvement in quality of life as corroborated by the caregiver's report [10].

This case has several important limitations. As a single case report, it does not permit conclusions regarding efficacy, and the simultaneous continuation of conventional palliative care

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introduces significant confounding. The absence of standardised validated outcome measures (such as the Confusion Assessment Method [CAM], Pittsburgh Sleep Quality Index [PSQI], or formal pain scales beyond VAS notation) limits the rigour of outcome documentation. Additionally, the natural trajectory of delirium, which may partially resolve spontaneously following stabilisation of precipitating medical factors, cannot be ruled out as an explanation for some of the observed improvement.

Notwithstanding these limitations, the case contributes to a small but emerging body of observational literature suggesting that individualised homeopathic treatment may offer a safe, tolerable, and potentially beneficial adjunct in geriatric palliative care, particularly for the management of behavioural disturbance, pain, and functional decline in patients for whom standard pharmacological options carry significant risk.

Conclusion

This case illustrates the potential role of individualised homeopathic therapy as an integrative component of geriatric palliative care in a patient with post-hospitalisation hyperactive delirium superimposed on severe dementia and advanced multimorbidity. Clinically significant improvements were observed across behavioural, pain-related, respiratory, nutritional, and functional domains, with no further hospitalisation during the eight-month period of homoeopathic care. The patient died peacefully at home, with relative consciousness and comfort, which is consistent with his palliative care goals.

The findings of this case must be circumspected in the absence of a controlled study design. However, they support the potential utility of integrative homeopathic management in this vulnerable population and provide a foundation for prospective documentation using standardised outcome measures. Future research employing validated instruments, longitudinal follow-up, and comparative or controlled designs is warranted to formally evaluate the safety and efficacy of homeopathic integration in geriatric delirium and palliative care.

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