International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

LM Potency in Skin Diseases: A Review of the Fifty-Millesimal Scale, Therapeutic Rationale, Clinical Applications and Current Evidence

Dr. Vivek Kumar Sao

BHMS Professor & Head, Department of Homoeopathic Pharmacy, Valan Homoeopathic Medical College & Hospital, Valan, Dist. Vadodara, Gujarat, India
dr.viveksao@gmail.com

Abstract

Background: Chronic skin diseases such as psoriasis, atopic eczema, acne, urticaria and vitiligo are among the most common reasons patients seek homoeopathic care in India. The fifty-millesimal (LM or Q) potency, described by Hahnemann in the sixth edition of the *Organon of Medicine*, is increasingly used for these conditions because it allows frequent, gently graded repetition with fewer aggravations.

Objective: To review the history, pharmaceutical preparation, posology and therapeutic rationale of LM potency, and to summarise current clinical evidence for its use in dermatology.

Methods: Narrative review of the *Organon* (6th edition), standard texts on homoeopathic pharmacy and philosophy, and published clinical studies, case reports and registered trials on LM potency in skin diseases, identified through PubMed, LILACS, publisher databases and the Clinical Trials Registry of India (CTRI).

Results: LM potencies are prepared at a dilution ratio of 1:50,000 at each step, starting from the 3C trituration. Their main clinical features are mild initial action, the possibility of daily or alternate-day repetition, and dose modification by succussion before each dose. The strongest dermatological evidence is a double-blind, placebo-controlled trial in psoriasis vulgaris (n = 51) favouring individualised medicines in LM potency on PASI at six months. A pilot randomised comparison (n = 10) and several case reports and series also report benefit. Most other data come from small, uncontrolled studies, and several trials in eczema, acne and urticaria are registered but not yet reported.

Conclusion: LM potency is a well-founded and practical posology for chronic, relapsing skin disease, especially in sensitive patients and in cases at risk of aggravation or suppression. Larger, adequately powered randomised trials comparing LM with centesimal potencies are needed.

Keywords: Fifty-millesimal potency; LM potency; Q potency; Organon 6th edition; dermatology; psoriasis; atopic eczema; homoeopathic pharmacy; posology

1. Introduction

Skin diseases are among the leading causes of non-fatal disease burden worldwide, and in India they form a large share of outpatient visits in both conventional and AYUSH settings. Psoriasis alone affects an estimated 0.4–2.8% of the Indian population [1]. Conditions such as psoriasis, atopic eczema, chronic

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

urticaria, acne vulgaris, lichen planus and vitiligo are chronic, relapsing and visible. They carry a heavy psychosocial cost and often need long-term treatment.

Conventional management relies largely on topical and systemic corticosteroids, immunosuppressants and, increasingly, biologics. These are effective for control but are often limited by relapse on withdrawal, cost and adverse effects. Many patients therefore turn to homoeopathy, and skin complaints are among the most frequent presentations in homoeopathic outpatient departments.

Homoeopathy views most chronic skin diseases as the outward expression of an internal, constitutional (miasmatic) disorder rather than a purely local problem [2,3]. Treatment is individualised and often prolonged. This makes the choice of potency and posology as important as the choice of remedy. A posology that is too strong risks marked aggravation of an already distressing eruption, while one that is too infrequent prolongs treatment.

The fifty-millesimal (LM) scale, Hahnemann's final refinement of potentisation, was designed to address exactly this problem. This review describes its origin, preparation and method of use, explains why it suits dermatological practice, and appraises the clinical evidence available up to 2026.

2. Historical background

Hahnemann first used the centesimal scale, and through five editions of the *Organon* (1810–1833) he advised a single dose followed by waiting. In practice this "wait and watch" method often produced strong initial aggravations and slow progress in chronic disease. From about 1837–1838, while practising in Paris, he experimented with a new method of preparation and repetition. Adler's study of the Paris casebooks identified 681 prescriptions in the new "Q" potencies [4].

Hahnemann described the method in the sixth edition of the *Organon*, completed in 1842, a year before his death. The manuscript remained unpublished for almost eighty years. Richard Haehl published it in German in 1921, and William Boericke's English translation followed in 1922 [2]. The method is set out mainly in §§246–248 (repetition and modified doses) and §270 (preparation).

Hahnemann himself gave the new scale no name. The term "LM" (Roman L = 50, M = 1,000) and the term "Q" (from *quinquagintamillesimal*) were introduced later. Pierre Schmidt of Geneva did much to revive clinical interest in the mid-twentieth century. In Brazil, Adler and colleagues standardised LM preparation and posology over fifteen to twenty years and reported fewer aggravations with standardised preparations [5,6]. In India, LM potencies are prepared by major manufacturers and taught in the BHMS pharmacy and Organon curricula.

3. Preparation of the fifty-millesimal scale

Each LM step dilutes the medicine about 1 in 50,000: a 1:100 dilution in liquid, followed by medication of globules of which one is roughly 1/500 of a drop. Hahnemann's method in §270 [2] can be summarised as follows.

1. **Trituration to 3C.** The crude drug (or mother tincture, for liquids) is triturated with sugar of milk in three stages of 1:100 each, giving the 3C trituration.

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

2. **Solution.** One grain (about 62 mg) of the 3C trituration is dissolved in 500 drops of a mixture of one part alcohol and four parts distilled water.
3. **First potentisation.** One drop of this solution is placed in a vial with 100 drops of strong alcohol and given 100 strong succussions. This is the medicinal liquid of the first degree.
4. **Medication of globules.** Poppy-seed-sized sugar globules (about 100 weigh one grain, roughly 500 per drop) are moistened with this liquid and dried. One globule is LM 1 (0/1).
5. **Next degree.** One dry globule of LM 1 is dissolved in one drop of water, 100 drops of alcohol are added, the vial is succussed 100 times, and fresh globules are medicated. This gives LM 2. The cycle is repeated to LM 30 and beyond.

The small globule size is essential: it keeps the 1:50,000 ratio and is why Hahnemann regarded LM potencies as more powerful yet gentler in action than centesimal potencies [2,7]. In practice, the potency is written as 0/1, 0/2 … 0/30 or LM 1 … LM 30. Accuracy of globule size, number of succussions and alcohol strength are the main quality variables. The Brazilian group showed that standardising these reduced clinical aggravations [6]. Hospital and college pharmacies preparing their own LM stock should therefore follow a written standard operating procedure.

4. Administration and posology

The LM method differs from the single-dose centesimal method mainly in how the dose is given and repeated. Its rules come from §§246–248 and §§280–285 of the sixth edition [2].

- **Liquid dose.** One globule is dissolved in a vial of about 7–8 tablespoons of water with a little alcohol as preservative (§248). From this stock, one teaspoon or tablespoon is stirred into a cup of water, and a measured part of the cup is taken as the dose. More dilution cups make the dose milder for sensitive patients.
- **Succussion before each dose.** The stock vial is succussed 8, 10 or 12 times before every dose (§248). This slightly raises the potency each time, so the vital force never receives an identical dose twice. Hahnemann considered this the key to safe repetition.
- **Frequency.** In chronic disease, a dose may be repeated daily or on alternate days for as long as improvement continues (§248). In acute states it may be repeated every few hours.
- **Progression.** Treatment starts at a low degree, usually LM 1, and moves up step by step (LM 2, LM 3 …) as each vial is finished, as long as the remedy remains indicated.
- **Aggravation.** If the original symptoms intensify towards the end of treatment, the dose is reduced or paused (§§281–282). A strong aggravation early in treatment suggests the dose is too large.
- **External route.** In chronic disease, the same medicinal solution may also be rubbed into healthy skin, away from the eruption, while it is taken internally (§§284–285). Hahnemann did not advise applying medicines to the local lesion itself.

A practical feature for dermatology is that potency and dose can be adjusted continuously. Instead of the coarse steps between 30C, 200C and 1M, the physician can vary dilution cups, number of succussions and frequency to match the patient's sensitivity.

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

5. Therapeutic rationale in skin diseases

Five features of chronic skin disease make the LM method a logical choice.

5.1 Chronic, miasmatic nature. In *The Chronic Diseases* and §§80–81 of the *Organon*, Hahnemann traced most chronic disease to psora, whose first expression is a skin eruption [2,3]. Psoriasis, eczema and similar dermatoses therefore usually need deep-acting antimiasmatic remedies (Sulphur, Psorinum, Graphites, Arsenicum album, Calcarea carbonica and others) over months. LM potencies allow such remedies to be repeated steadily over this period without the long pauses of the single-dose method.

5.2 Avoiding distressing aggravation. Homoeopathic aggravation of an itching or weeping eruption is uncomfortable and often leads patients to stop treatment. LM potencies were introduced precisely to reduce such aggravations [2]. Clinical reports in psoriasis and eczema describe improvement with little or no aggravation [8,9]. This is especially useful in children, the elderly and highly sensitive patients.

5.3 Avoiding suppression. §§185–203 warn that removing a local eruption by external means drives the disease inward and may cause more serious internal illness. Many patients arrive after long use of topical steroids. A gentle, continuously adjustable internal posology lets the physician treat the whole case and watch for return of old symptoms, in line with Hering's observations on direction of cure.

5.4 Fine control in mixed and changing cases. Skin cases often show alternation of symptoms (for example eczema with asthma) or change in picture over time. Because the dose can be reduced, paused or raised step by step, the physician can follow the case closely and change the remedy without the confusion of a large, long-acting dose.

5.5 Patient compliance. Daily liquid doses fit modern expectations of regular medication. The routine of succussing and diluting also involves the patient in treatment. The main compliance risk is error in preparing doses, which requires clear written instructions.

6. Clinical applications

In every condition below, the remedy is chosen on the totality of symptoms, not on the diagnosis. The remedies listed are those most frequently indicated in standard materia medica and repertories [10,11], and are offered as guides for study, not as fixed prescriptions.

Condition	Points relevant to LM use	Frequently indicated remedies
Psoriasis	Chronic, relapsing, often post-steroid; long treatment needed; best studied condition for LM	Arsenicum album, Sulphur, Graphites, Petroleum, Kali arsenicosum, Mezereum, Sepia, Calcarea carbonica
Atopic eczema	Common in children; itching and weeping make aggravation poorly tolerated; often alternates with asthma or rhinitis	Sulphur, Graphites, Psorinum, Calcarea carbonica, Mezereum, Hepar sulphuris, Rhus toxicodendron, Natrum muriaticum

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

Condition	Points relevant to LM use	Frequently indicated remedies
Acne vulgaris	Adolescents and young adults; hormonal and emotional factors; slow, steady progress expected	Kali bromatum, Hepar sulphuris, Silicea, Pulsatilla, Calcarea silicata, Sulphur, Natrum muriaticum
Chronic urticaria	Recurring wheals over weeks to years; daily dosing suits fluctuating course	Apis mellifica, Urtica urens, Rhus toxicodendron, Natrum muriaticum, Calcarea carbonica, Dulcamara, Astacus
Lichen planus	Intense itching; skin and mucosa; slow response	Arsenicum album, Nitricum acidum, Natrum muriaticum, Staphysagria, Lachesis, Kali iodatum
Vitiligo	Very chronic; psychosocial impact; months of treatment before repigmentation	Arsenicum sulphuratum flavum, Sepia, Natrum muriaticum, Sulphur, Calcarea carbonica, Phosphorus
Warts and corns	Often constitutional; LM allows steady repetition	Thuja occidentalis, Causticum, Nitricum acidum, Antimonium crudum, Dulcamara

A typical prescription starts with the indicated remedy in LM 1 (0/1), one dose daily from a 7–8 tablespoon vial with 8–10 succussions before each dose. The patient is reviewed every two to four weeks. Each new vial moves to the next degree if improvement continues. Severity is best recorded with validated scales so that outcomes can be audited: PASI for psoriasis, EASI or SCORAD for eczema, the Global Acne Grading System for acne, UAS7 for urticaria and VASI for vitiligo.

Skin cases need extra care in follow-up. A temporary return of an old eruption or discharge, with general improvement, is usually a good sign and should not be suppressed. Spreading eruption with general worsening calls for review of the remedy or dose. Severe forms (erythrodermic or pustular psoriasis, eczema herpeticum, angio-oedema with airway involvement) need conventional emergency care first.

7. Current evidence

The best evidence for LM potency in skin disease is one double-blind, placebo-controlled trial in psoriasis; the rest is small comparative, observational or case-level data.

Psoriasis. Balamurugan and colleagues at the National Institute of Homoeopathy, Kolkata, randomised 51 patients with psoriasis vulgaris to individualised medicines in LM potency (n = 25) or identical placebo (n = 26) for six months (CTRI/2019/11/021917) [1]. Both groups improved, but PASI reduction was significantly greater with active treatment at six months ($F = 10.448$, $p = 0.002$). The DLQI daily-activity subscale also favoured active treatment ($p = 0.023$). In a pilot randomised trial at Jawaharlal Nehru Homoeopathic Medical College, Vadodara, Nayak et al. compared LM and centesimal potencies in 10 patients, with the remedy individualised and only the potency scale varied [12]. Both groups improved significantly over six

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

months, and the LM group showed greater PASI reduction (between-group p = 0.041). A single case of psoriasis in a 24-year-old man treated with LM potency, reported by Gupta and Lamba, showed favourable response without aggravation [8].

Atopic eczema. A German case series treated 19 patients with individualised Q (LM) potencies under a standardised method [9]. Over a mean of 8.8 months, EASI fell significantly (p = 0.015). Seventeen patients (89%) had more than 50% reduction in EASI, with a mean response time of 3.7 months.

Other indications. An MD thesis from Rajiv Gandhi University of Health Sciences compared LM and centesimal potencies in 60 patients with mixed acute and chronic conditions and reported faster improvement with LM potencies [13]. A vitiligo study from Howrah used both scales according to individual need, measured with VASI and VIS-22 [14]. Outside dermatology, a Brazilian double-blind trial found individualised Q potencies non-inferior to fluoxetine in moderate-to-severe depression, which supports the feasibility of LM posology in controlled trials [15].

Study	Condition	Design	n	Main finding
Nayak et al. 2025 [12]	Psoriasis	Pilot RCT, LM vs centesimal	10	Greater PASI reduction with LM (p = 0.041)
Gupta & Lamba 2024 [8]	Psoriasis	Case report	1	Improvement without aggravation
Balamurugan et al. 2023 [1]	Psoriasis vulgaris	Double-blind RCT, LM vs placebo	51	Greater PASI reduction with LM at 6 months (p = 0.002)
Q-potency series 2010 [9]	Atopic eczema	Prospective case series	19	89% had >50% EASI reduction; mean response 3.7 months
Sumanth (MD thesis) [13]	Mixed conditions	Comparative, LM vs centesimal	60	Faster improvement reported with LM

Registered trials awaiting results. Several Indian trials registered with CTRI should add to this evidence base:

- CTRI/2025/03/082231, Calcutta Homoeopathic Medical College: centesimal vs 50-millesimal potency in acne vulgaris, open-label randomised, target 90 patients [16].
- CTRI/2025/03/081730: LM potency in atopic eczema, open-label observational, outcomes EASI, vIGA-AD and DLQI [17].
- CTRI/2025/12/099773, National Institute of Homoeopathy: LM potency and absolute eosinophil count in paediatric atopic dermatitis, single-arm, target 50 [18].
- CTRI/2023/09/058058: centesimal vs LM potency in psoriasis, PASI at 3 and 6 months [19].
- CTRI/2022/06/043474, Bakson Homoeopathic Medical College: centesimal vs fifty-millesimal potencies in chronic urticaria [20].

International Journal of Advanced Multidisciplinary Research and Innovation
E-ISSN: 3107-6157 editor@ijamri.com
Volume 2, Issue 6, November-December 2026

Appraisal. The evidence is promising but limited. Only one trial is placebo-controlled and adequately blinded, and it tested individualised homoeopathy in LM potency rather than LM against other scales. The only randomised LM-versus-centesimal comparison had ten patients and cannot establish superiority. Case reports and uncontrolled series cannot separate treatment effect from natural fluctuation, regression to the mean and placebo response, which are all large in relapsing skin diseases. Critics have also questioned the biological plausibility of any effect. The registered comparative trials above, if completed and reported in full, will be the most useful next step.

8. Advantages, limitations and future directions

Advantages in dermatology	Limitations and challenges
Fewer and milder aggravations, important in itching or weeping eruptions	Preparation is laborious; globule size and succussion are hard to standardise
Daily or alternate-day repetition shortens chronic treatment	Daily dosing needs good patient understanding and compliance
Dose adjustable by dilution, succussion and frequency	Errors in home preparation of doses are common
Suits children, elderly and sensitive patients	Few physicians are trained in sixth-edition posology
Helps avoid suppression in post-steroid cases	Evidence base small; few head-to-head trials

Future directions. Five steps would strengthen both practice and evidence:

1. Pharmacopoeial standardisation of globule size, alcohol strength and succussion for LM stock, with quality checks in teaching-hospital pharmacies.
2. Adequately powered, randomised LM-versus-centesimal trials in psoriasis, atopic eczema and chronic urticaria, using PASI, EASI/SCORAD, UAS7 and DLQI.
3. Systematic recording of aggravations and adverse events, which is central to the claimed advantage of LM potency.
4. Multicentre clinical verification studies through CCRH and NCH-affiliated colleges.
5. Inclusion of practical LM dispensing and patient-instruction training in the BHMS pharmacy and Organon curriculum.

9. Conclusion

The fifty-millesimal potency is Hahnemann's most refined posology, and its features—mild action, safe repetition and finely adjustable dose—fit the needs of chronic, relapsing and often previously suppressed skin diseases. A double-blind trial in psoriasis and several smaller studies support its use, but the evidence is still limited in size and quality. Homoeopathic physicians and pharmacists should prepare and dispense LM potencies to a written standard, record outcomes with validated dermatological scales, and contribute to well-designed comparative trials.

Conflict of interest: None declared. **Funding:** None.

References

1. Balamurugan D, Nayak C, Chattopadhyay A, Karuppusamy A, Ambrose MM, Kumar A, et al. Individualized homeopathic medicines in the treatment of psoriasis vulgaris: double-blind, randomized, placebo-controlled trial. Complement Med Res. 2023;30(4):317–31. Link
2. Hahnemann S. Organon of Medicine. 6th ed. Translated by Boericke W. New Delhi: B. Jain Publishers; reprint edition.
3. Hahnemann S. The Chronic Diseases: Their Peculiar Nature and Their Homoeopathic Cure. Translated by Tafel LH. New Delhi: B. Jain Publishers; reprint edition.
4. Adler UC. Nachweis von 681 Q-Potenzen in den französischen Krankenjournalen Samuel Hahnemanns. Med Ges Gesch. 1994;13:135–66.
5. Adler UC, Cesar AT, Adler MS, Alves A, Garozzo EN, Galhardi WMP, et al. LM or Q potencies: review of their use over a fifteen-year period. Homœopathic Links. 2005;18(2):87–91. doi:10.1055/s-2005-837714. Link
6. Adler UC, et al. From pharmaceutical standardizing to clinical research: 20 years of experience with fifty-millesimal potencies. Int J High Dilution Res. 2009;8(29). Link
7. Mandal PP, Mandal B. A Textbook of Homoeopathic Pharmacy. Kolkata: New Central Book Agency; latest edition.
8. Gupta AK, Lamba P. Homoeopathic treatment of psoriasis using fifty-millesimal (LM) potency: a case report. Altern Ther Health Med. 2024;30(7):50–3. PMID: 39110043. Link
9. [Authors to be verified]. Der Einsatz von Q-Potenzen bei atopischem Ekzem: Bericht über eine Fallserie [Use of Q-potencies in atopic eczema: a case series]. 2010. doi:10.1055/s-0029-1242609. Link
10. Boericke W. Pocket Manual of Homoeopathic Materia Medica and Repertory. New Delhi: B. Jain Publishers; reprint edition.
11. Kent JT. Repertory of the Homoeopathic Materia Medica. New Delhi: B. Jain Publishers; reprint edition.
12. Nayak A, Rawal H, Desai P, Gohel R, Shah H. Comparative evaluation of centesimal and fifty-millesimal (LM) potencies in the homoeopathic management of psoriasis: a pilot randomized controlled trial. The Bioscan. 2025;20(4):1769–74. Link
13. Sumanth BL. A study on the efficacy of fifty-millesimal scale potency in clinical practice [MD (Hom.) dissertation]. Bangalore: Rajiv Gandhi University of Health Sciences. Link
14. Effectiveness of individualized homoeopathic medicine in treatment and assessment of quality of life in vitiligo: a pre-post interventional study [dataset]. Mendeley Data. 2026. doi:10.17632/28r28jck43.1. Link
15. Adler UC, Paiva NMP, Cesar AT, Adler MS, Molina A, Padula AE, et al. Homeopathic individualized Q-potencies versus fluoxetine for moderate to severe depression: double-blind, randomized non-inferiority trial. Evid Based Complement Alternat Med. 2011;2011:520182.
16. CTRI/2025/03/082231. Individualized homoeopathic medicines in centesimal versus 50-millesimal potency in acne vulgaris. Link
17. CTRI/2025/03/081730. Individualized homoeopathic medicine in atopic eczema using fifty-millesimal potency. Link

18. CTRI/2025/12/099773. Individualized homoeopathic medicines in 50-millesimal potency and absolute eosinophil count in paediatric atopic dermatitis. Link
19. CTRI/2023/09/058058. Individualised homoeopathic medicine in centesimal versus LM potencies in psoriasis. Link
20. CTRI/2022/06/043474. Role of homoeopathy in the treatment of chronic urticaria (centesimal vs fifty-millesimal potencies). Link