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ORIGINAL ARTICLE

Clinical Outcomes of Homeo pathic Constitutional Treatment Added to Long-Term Allopathic Therapy in Parkinson's Disease and Bone Degeneration - Cross-Validation of the Veredas Protocol

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ABSTRACT

Objectives: *To assess the clinical effects of adding individualized homeopathic treatment, based on the Effective Dose 100% (DE100) model, to ongoing allopathic treatment in patients with Parkinson's disease or degenerative bone disorders. The study also explores the use of the Veredas App as a tool for personalized dose management.* ***Methods:*** *In this mixed-methods study, 35 patients previously treated with allopathic medications (mean duration: 60.5 months) received a one-month course of constitutional homeopathic medicines prescribed using DE100 logic. Symptoms were scored on a 0–4 scale in real time, using the Veredas mobile application to identify each patient's worst (PM) and best (MM) daily moments. Symptom patterns were recorded over 28 days. Eleven cases were also analyzed via video to compare responses to allopathic (DE50) and homeopathic (DE100) treatment phases.* ***Results:*** *Previously published outcomes using the Veredas Protocol showed symptom improvements of 60.2% (chronic pain), 91% (Parkinson's), and 85% (emotional/mental health). In this study, 57.7% clinical improvement was observed after adding homeopathy. Patient self-assessments via the app showed 77% concordance with independent video analysis. While DE50-based treatments yielded limited changes, DE100-guided dosing achieved similar or greater results in one month using potencies averaging CH15.* ***Conclusions:*** *Although this study was not designed to compare DE50 and DE100 as conceptual frameworks, the findings suggest that individualized timing of dose administration may play a key role in clinical improvement. The Veredas App shows promise as a precision-prescribing tool. Further studies should explore the influence of dosing logic on treatment efficacy, independent of the medication paradigm.*

Keywords: *Parkinson's disease, Homeopathy, Dose-response relationship, Individualized medicine, Veredas Protocol, Effective Dose 100 (DE100).*

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INTRODUCTION

Idiopathic Parkinson's Disease (IPD) is a chronic neurodegenerative condition affecting approximately 1–2% of the global population over the age of 65[13,14]. The constitutional homeopathic approach (MC) involves the use of substances that elicit symptoms in healthy individuals, which, when administered homeopathically, can relieve similar symptoms in patients[1,2].

Current allopathic treatments, such as dopamine replacement therapy, offer temporary symptomatic relief but are frequently associated with long-term motor complications. Levodopa, in particular, is linked to dose accumulation under the Effective Dose 50% (DE50) model, which may contribute to adverse effects and reduced therapeutic efficacy over time[11,12].

Homeopathy presents a potential alternative in the management of IPD, especially when guided by the Hahnemannian principle of the Effective Dose 100% (DE100), as described in §248 of the *Organon*. This approach aims to minimize cumulative toxicity by adjusting doses based on real-time clinical indicators, especially during the patient's most symptomatic periods (Pior Momento – PM)[1,2]. Previous reports have indicated that prolonged use of DE50-based allopathic regimens can lead to hospitalizations and, in some cases, fatalities due to adverse effects[11,12].

The Veredas Protocol, developed over 16 years, uses a dedicated software platform to individualize dosing through

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daily symptom self-assessment. Patients score their symptoms on a 0–4 scale across 13 waking hours, identifying their worst (PM) and best (MM) moments, allowing for targeted dose administration. This protocol was applied to 35 patients with neurodegenerative and bone disorders, including IPD, and outcomes were analyzed using both quantitative tracking and qualitative video assessments[20–28].

While the focus of many comparative studies has been the distinction between medication types (allopathic vs. homeopathic), this study emphasizes a different hypothesis: that the **logic of dose prescription itself — fixed intervals in DE50 versus individualized timing in DE100 — may be a critical determinant of therapeutic response**. Although the present design does not allow for a direct comparison between these two conceptual models, the clinical improvements observed following DE100-guided homeopathic intervention suggest that **dose individualization in real time may play a more decisive role than the nature of the medication alone**.

This study aims to explore these possibilities through a primarily qualitative analysis, supported by patient-reported scores and external video evaluations, and to contribute to the broader discussion on how dosing strategies — not only substances — shape clinical outcomes in chronic degenerative conditions.

Study Design: This is a prospective, observational, and exploratory study, summarized below and detailed in subsequent sections.

The study followed a qualitative observational design with cross-validation. Clinical evaluations focused on symptom severity using 0–4 scores, particularly during the patient's worst moment (PM) related to gait or tremor symptoms in individuals with Parkinson's disease. Assessments were conducted after the administration of a single dose of a constitutional homeopathic medicine. The Veredas Protocol was employed to guide and monitor treatment, using hourly symptom records via the Veredas mobile application. **Clinical improvement was further validated by short video recordings, with external evaluation conducted by an independent reviewer, showing a 77% agreement with the quantitative self-assessments submitted via the Veredas app.**

The distinction between **Phase 1**, in which patients used only allopathic medications for Parkinson's disease over an average of 60.5 months, and **Phase 2**, in which a constitutional homeopathic medicine was added for just one month, does not lie solely in the time frame. More importantly, it reflects a conceptual shift: from the allopathic dosage logic based on the Effective Dose 50% (DE50), commonly used in pharmaceutical protocols, to the Hahnemannian concept of Effective Dose 100% (DE100), applied during Phase 2.

The theoretical framework of the Veredas Protocol is essential for understanding the study and is provided in detail in the section *Theory and Methodology* (see Annexes and Supplemental Materials, "Paste 2.zip"). The full research structure is presented in *Annex 3*, which includes all phases of the study across nine components. These materials contain recruitment content shared via social media, training materials for four assistants (who supported patients in four online groups), individualized prescriptions issued by each assistant group, and pharmacy coordination. Volunteers were recruited from various regions of Brazil.

The homeopathic medicinal products were authorized by the national agency of sanitary surveillance-ANVISA (Decree No. 79094, published in the Official Gazette in 5/1/77) and by The National Ethics Committee approved the project as indicated by the Brazil Platform on 10/31/2021, under the number CAAE: 52986221.9.0000.5133.

Data Collection and Procedure

At the initial consultation, patients or their caregivers were instructed to complete daily symptom records at home, using a 0–4 scale to assess both mental/emotional symptoms (for constitutional diagnosis) and their primary Parkinson's symptom (either gait or tremor). Parkinson's symptoms were rated using descriptors derived from the Unified Parkinson's Disease Rating Scale (UPDRS), with scores ranging from 0 (no symptom) to 4 (severe), increasing in intensity and frequency. Separate analyses were conducted to calculate mean scores for each of the two symptom categories.

From the beginning, participants were trained to use the scoring system through explanatory meetings and video tutorials under the guidance of four trained research assistants. They learned how to interpret both emotional and motor symptom descriptors. An additional explanatory video on the use of the Veredas App was recorded by the principal investigator (see *Annex 3 – Item 3.4*), guiding patients to identify their most disabling symptom (gait or tremor) for tracking.

On the 30th day of exclusive allopathic Parkinson's treatment (mean duration: 60.5 months), patients received an initial prescription of a constitutional homeopathic medicine (CM), administered as two drops in the morning, following a remote individual consultation with the study physician. Potencies were increased individually every four days, following the Veredas Protocol's sequence of seven doses: CH6, CH9, CH12, CH16, CH20, CH30, CH40, CH50, and CH60.

Approximately 45 different homeopathic constitutional medicines were donated by 13 homeopathic pharmacies from various Brazilian states. The individualized homeopathic treatments were mailed to participants at their home addresses.

Training materials, WhatsApp guidance, and monitoring protocols are detailed in the Supplemental Materials (*Annex 3*).

Throughout the study, patients continued their usual medications as prescribed by their neurologists. The comparison was restricted to scores 3 and 4 reported during the worst moments in Phase 1 (allopathic treatment) and their corresponding values in Phase 2 (with added homeopathic treatment), ensuring clear focus on clinically significant changes — a critical element in qualitative analysis.

Cross-validation was performed by comparing app-based self-assessments with video recordings. During the two-month study period, the Veredas App issued automated alerts for data entry and score validation. After the second month, the

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author independently reviewed the video records, confirming a 77.1% agreement with the app-based scores. This methodological triangulation added credibility to the qualitative findings, mitigating subjectivity — a common critique of qualitative health research.

The use of an app with automated alerts and standardized score descriptors (e.g., "step length = 1/4 of foot") introduced a rare level of methodological consistency in a qualitative study, enhancing alignment with observational validation criteria.

Technical Description of Clinical Markers

To standardize and ensure consistency in qualitative data, five clinical markers were defined to assess patient progress throughout the study. These markers were applied to both the daily spreadsheet entries and the video recordings submitted by patients, enabling a reliable alignment between score variations (0–4) and clinical observations.

Below is a description of the five primary quantitative markers later cross-referenced with qualitative data (evolutionary videos):

Summary 1 – Identifying the Optimal Dose Using the Veredas App

1. **WM (Worst Moment):**
   The moment when the selected symptom (gait or tremor) reaches its peak intensity, scored from 0 to 4 with descriptive states. This may occur multiple times per day and serves as the criterion for taking the next dose of any repeating medication. Identifying the WM ensures that the previous dose has fully dissipated (100% clearance), thus avoiding dose overlap. A reduction in the frequency of WM events during the day is expected to correlate with a reduction in dosage until its complete suspension.
2. **BM (Best Moment):**
   The moment of greatest symptom relief for the selected gait or tremor issue, also scored from 0 to 4 with descriptive parameters. This serves as a clinical indicator of improvement and balance in motor response.
3. **Hs WM (Hours of Worst Moment):**
   The cumulative number of hours per day during which WM events occur. This marker quantifies the duration of symptomatic exacerbation and may appear multiple times in a day. It is used to track reduction in symptom burden across the treatment period.
4. **Hs BM (Hours of Best Moment):**
   The cumulative number of hours per day during which BM events are recorded. As symptom control improves, Hs BM is expected to increase. Six hours per day was used as a reference threshold for positive clinical response.
5. **Mean Score and Coefficient of Cure (Coef):**
   The daily mean score was calculated to evaluate the trend in clinical progression.
6. The **coefficient of cure** was defined as the ratio between BM periods (and Hs BM) and WM periods (and Hs WM), providing a composite measure of symptom improvement and treatment effectiveness.
7. **Texto introdutório para a Table I** Table I summarizes the best clinical outcomes observed for each tested dose across a four-day evaluation period, as identified through the markers described in Summary 1. Each row represents a specific dose and its associated results in terms of motor symptom evolution. These outcomes are interpreted in conjunction with the patient's general clinical context, as the optimal dose is not defined solely by numerical values but also by individual response patterns.

Table – I: Summary 2 – Consolidated Analysis of Dose Response

Index	Confusions	Syntom	Taking day	Drug Dosis	CH	OT	Média	WM	HsWM	BM	HsBM	Coef
2	-None	March	16/09/2024	DNA12 OT Ossos CH14/OT Cerebro +Hipocampo CH45	DNA, ATP	1.89	4	7	0	7	0.27	
3	None	March	24/09/2024	ATP CH16-	DNA, ATP	1.11	4	3	0	13	0.09	
1	None	March	29/09/2024	ATP CH18	DNA, ATP	1.63	4	6	0	10	0.16	
1	Abdom pain	March	06/10/2024	ATP CH16- Abdominal pain	DNA, ATP	1.74	4	6	0	8	0.22	
4	None	March	12/10/2024	DNA CH12	DNA, ATP	1.37	4	6	0	12	0.11	
2	None	March	14/10/2024	Continuation DNA CH12	DNA, ATP	1.58	4	6	0	10	0.16	
3	-None	March	19/10/2024	Continuation DNA CH12	DNA, ATP	1.84	4	7	0	8	0.23	

Drugs: OT – Organotherapic; DNA CH12 – DNA, Homeopathic Blood Patient DNA Dose CH12; ATP – Adenosine Triphosphate, CH 12, 45, 6, 18,16 (test doses); WM – Worst Moment; HsW – Hours of WM; BM – Best Moment; HsB – Hours of BM; Coef. – Healing Coefficient.

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Example of Results Interpretation of Table 1 to check the best dose and the dose test evolution:

As shown in Table 1 - Summary 2 (is the summary of Summary 1)

Best CH Dose: ATP CH16, with an average score of 1.11 on September 24, 2024. This dose resulted in:

Significant increase in Best Moment (BM) hours: From 7 to 13 hours per day (BM = 0).

Reduction in Worst Moment (WM) hours: From 7 to 4 hours per day (WM = 4).

Compared to a previous average of 1.89, with similar variations in other indicators.

Worsening with CH18: On September 29, 2024, CH18 led to deterioration, with an average score of 1.63, worse than the previous CH16 score of 1.11.

Reversal Attempt with CH16: Returning to CH16 on October 6, 2024, did not reverse the worsening, attributed to the emergence of a comorbidity (colon cancer) with average score of 1,74, worsed from 10 hours per day (BM=0) to 8 hours per day(MM=0) and maintaining the same 6 hours per day (WM=4)

Criteria for Determining the Optimal Dose

The best dose was identified by evaluating the five markers, with criteria including:

Highest number of daily hours with BM.

Lowest average scores.

Fewest daily hours with WM.

Example of Results Interpretation from Table I

Example of Dose Response Interpretation – Table I

As shown in Table 1 (Summary 2, which consolidates Summary 1), the optimal dose was identified as **ATP CH16**, administered on **September 24, 2024**, with an **average clinical score of 1.11**. This dose yielded:

- A significant **increase in Best Moment (BM) hours**, rising from 7 to **13 hours/day**, with BM rated as 0;
- A **reduction in Worst Moment (WM) hours**, dropping from 7 to **4 hours/day**, with WM rated as 4;
- Improvement over a previous dose that had produced a higher average score of 1.89, despite similar trends in other indicators.

Worsening with CH18:

On **September 29, 2024**, administration of **CH18** resulted in clinical deterioration, with the average score increasing to **1.63**, reversing prior gains.

Attempted Reversal with CH16:

A return to CH16 on **October 6, 2024**, failed to reverse the decline. The average score rose further to **1.74**, which coincided with the emergence of a comorbidity (diagnosed as colon cancer). BM hours decreased from 10 to 8 (still rated BM = 0), and WM hours remained unchanged at 6 (WM = 4).

Criteria for Determining the Optimal Dose

The best dose was determined by evaluating all five clinical markers, using the following criteria:

- The **highest number of hours per day with Best Moment (BM)**;
- The **lowest average clinical score** across the assessment period;
- The **fewest hours per day with Worst Moment (WM)**.

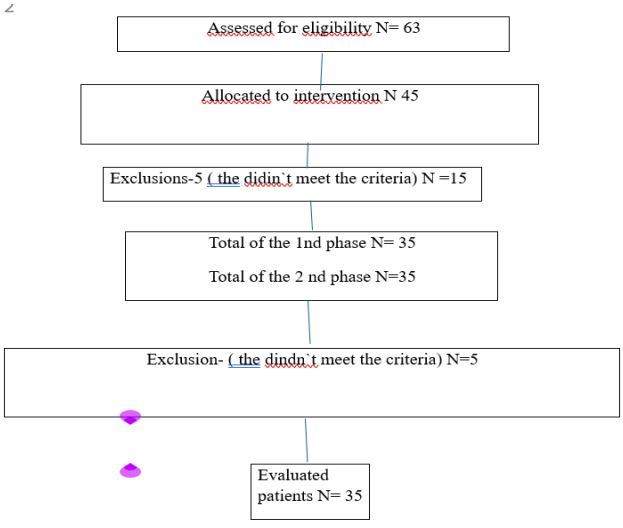
However, clinical judgment remains essential. The emergence of **comorbidities** or other confounding variables may require reassessment of the optimal dose. The Veredas App includes built-in logic to prioritize treatment of such intercurrent conditions before resuming dose progression. Only after managing the comorbidity is it advisable to resume testing higher potencies (e.g., CH18).

This process was conducted **individually for each of the 35 volunteers**, demonstrating the **precision, responsiveness, and practical utility** of the Veredas Protocol in identifying optimal therapeutic doses based on real-time clinical data.

RESULTS

1. Qualitative Study 1 – Participant Selection and Demographics

Figure 1



A detailed flowchart of participant inclusion and exclusion is presented in **Figure 1**.

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Demographic Characteristics

- **Age and Gender:**
  Parkinson's disease was more prevalent among **men aged 51–92** and **women aged 44–90**.
- **Regional Representation (RMBH – Metropolitan Region of Belo Horizonte):**
  The sample corresponded to **5.3% of men** and **11.3% of women** within the regional population of diagnosed individuals.
- **Educational Level:**
  An equal proportion of participants had completed either **primary education** or **higher education** (22% each).
- **Healthcare Access:**
  - **36%** of participants were covered by the public health system (SUS).
  - **32%** had access to private healthcare insurance.
- **Time Since Diagnosis:**
  - **12%** had been diagnosed within the last 5 years.
  - **18%** had been diagnosed between 6 and 10 years prior.
  - **12%** had a disease duration of 18 to 20 years.
- **Comorbidities:**
  Participants presented with an **average of 1.3 comorbidities**, ranging from **0 to 10** per individual.

Veredas App Evaluation – Dose Selection

The study also evaluated the **effectiveness of the Veredas App** in identifying the most appropriate dose among seven tested potencies for each participant.

A qualitative analysis was conducted using **video documentation from 9 of the 35 included volunteers**, focusing on:

- The evolution of symptom intensity across different potencies;
- The app's ability to assist in clinical decision-making regarding optimal dose selection;
- The correlation between app-based records and video-based external assessments.

Table – II: Reduction of Worst Moment Clinical Scores – Phase 1 to Phase 2

ID		FASE 1	FASE 2	FASE 1	FASE 2
		Hours WM- 3 e 4	Hours WM- 3 e 4	Hours BM -0-1-2	Hours BM-0-1-2
1	AMM			12	8
2	DLL	3		2	8
3	EMR	1		12	6
4	FTL	3		9	16
5	GP	12		7	16
6	GMS	5		12	10
7	JGGM	8		4	13
8	JCR			14	16
9	KCG		16	9	17
10	LC	7		2	15
11	LCN	2		14	14
12	MSE	2		2	5
13	MEFS			18	2
14	MRPM	2		5	3
15	NRNR	9		8	4
16	NFB	4		11	5
17	SPVS			8	5
18	TJG	3	10	3	2
19	VLG			14	19
20	CMC			4	5
21	DLP			6	12
22	EMR	1		14	17
23	IPNVS	9		8	12
24	JIP	18	19	18	16
25	JLA	1		9	16
26	MCA			18	7
27	MVBS			13	11
28	MIRS			14	9
29	MGO			13	10
30	NOR			6	16
31	RC			11	13
32	RFS			5	10
33	SPVS			13	2
34	DM	6		4	17
35	JM			13	17
Total-		95	45	335	374

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Interpretation of Phase 1 and Phase 2 Results

Note: Blank cells in the tables do not indicate missing data but rather the absence of severe symptoms (scores 3 or 4) during Phase 2. This absence is interpreted as a clinical indicator of improvement and is discussed in the main text.

From Phase 1 (allopathic treatment only) to Phase 2 (addition of constitutional homeopathic medication), there was a **52.6% reduction in the number of hours with Worst Moment (PM) scores of 3 or 4**, and a **10.4% increase in Best Moment (BM) hours**. This pattern reflects the logic of the Veredas Protocol, which prioritizes **dose administration exclusively during the PM** — that is, at moments of highest symptom intensity.

Importantly, score 4 was an exclusion criterion for study participation, meaning that **score 3 (intense symptom)** was the upper clinical threshold observed. According to protocol guidelines, once PM scores of 3 diminish and PM hours approach zero, the patient no longer presents intense symptoms and is transitioned to testing doses during moderate (score 2) or mild (score 1) symptoms. Thus, while improvement in PM hours may occur rapidly, this does not imply full clinical resolution or treatment discontinuation. Ongoing testing of potencies, consideration of comorbidities, and evaluation of possible confounding factors remain essential, given the **biochemical and energetic interconnection between organs and environmental factors**, which may modulate therapeutic response in both homeopathic and allopathic approaches to Parkinson's disease.

In Phase 1, the number of PM hours ranged from **1 to 18 hours per day**. In Phase 2, although some patients initially experienced increased PM hours (likely due to the surfacing of deeper symptom layers), these events began to shift from **score 3 (intense)** to **score 2 (moderate)** and **score 1 (mild)**. This clinical transition is evidenced by the near disappearance of score 3 in Phase 2.

Specifically, in Phase 1, **17 of the 35 volunteers presented PM scores of 3**. By the end of Phase 2, after just one month of constitutional homeopathic treatment, **only 3 patients still registered score 3**, reflecting an **83.35% improvement** in the number of hours with PM = 3 following the introduction of homeopathy.

Table – III – Reduction of Worst Moment Clinical Scores with Evolutive Videos

Patient	Phase 1 PM	Phase 2 PM	Videos (Before / After)
GMS	3	0	https://drive.google.com/file/d/17YVelOZtxDMZGH7drQNZKs_qX4WynnZ5/view?usp=sharing https://drive.google.com/file/d/1b4pEzjSIotHKyTPGkvH44g5I7JvwAlqE/view?usp=sharing
AMM	2	1	https://drive.google.com/file/d/1JDTwEnR9f0v8Kw630cjy6cqvuwhwp7UR/view?usp=sharing https://drive.google.com/file/d/1Zanp0NjBShcAzAH6llarbfn8XuvqKO5O/view?usp=sharing
DLL	3	1	https://drive.google.com/file/d/1_QUBTddSfHSi2yXdnTZN4yv7LqDVKbGe/view?usp=sharing https://drive.google.com/file/d/1GVAr0q6WoYPJZWKAmSSuDqTM55n7-wY3/view?usp=sharing
EMR	2	1	https://drive.google.com/file/d/1AREN7g1BU0O6tXxkfiXeMQOGb74abdHm/view?usp=sharing https://drive.google.com/file/d/1kuC0SMyqC-jaSoPv9-PSoe9LSwlUvqz7/view?usp=sharing
MEFS	3	2	https://drive.google.com/file/d/1IDxNPCpGELh8svQosjz6jVPk0LfG1LOB/view?usp=sharing https://drive.google.com/file/d/1emvcKlmdnTDUnJmNRWnqhn-xbx3AOHwx/view?usp=sharing
NOR	2	1	https://drive.google.com/file/d/1cVBjiLVeaaLqJt4-qE0EWT_tBeuFKpOa/view?usp=sharing https://drive.google.com/file/d/1Eq7BbJwBhC4Ywi5PQ9asmlKrSqUKUQs_/view?usp=sharing
MIRS	1	1	https://drive.google.com/file/d/1npyKfxp2Oif8qmO3C9ZbLF2VoyVbexSd/view?usp=sharing https://drive.google.com/file/d/1ftHTMj2KCQLderU2AZiT1s9WzmWfPyL1/view?usp=sharing
MSE	1	0	https://drive.google.com/file/d/1ZXRM8tMICBfPAO1h7lVJEf79AqDE4j1W/view?usp=sharing https://drive.google.com/file/d/1ocXEIO5NCZvZTVpouFCHE8aFjxM_-rwQ/view?usp=sharing
MVBS	1	0	https://drive.google.com/file/d/1H2IidLyyBRSAhj_Um-j9tfoL_O6JlrTt/view?usp=sharing https://drive.google.com/file/d/11a-HT2uFwQVpUdNpX4_N3aFg_KJPpdjh/view?usp=sharing
	18	7	

The comparative results of the Worst Moment (WM) videos between Phases 1 and 2 confirmed the improvements observed in Table III. Specifically, there was a 61.1% average reduction in WM scores from Phase 1 (allopathic treatment only) to Phase 2 (addition of constitutional homeopathic treatment). The video assessments for these 9 out of 35 volunteers were independently performed by the principal investigator, rather than by the volunteers themselves. This cross-validation of video scores substantially enhanced the credibility of the results.

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Table – IV: Increase of Best Moment Clinical Scores in Evolutive Videos

F	Fase 1	Fase 2	FASE 1 Video	FASE 2 Video
GMS	2	0	https://drive.google.com/file/d/17YVelOZtxDMZGH7drQNZKs_qX4WynnZ5/view?usp=sharing	https://drive.google.com/file/d/1fA4AE7eUgps0IRWVLosDmOviE4cVQ3eu/view?usp=sharing
AMM	1	1	https://drive.google.com/file/d/1JDTwEnR9f0v8Kw630cjy6cqvuwhwp7UR/view?usp=sharing	https://drive.google.com/file/d/1yiNwVNk0UhueABQl3zAIKqU_SDjtyq6D/view?usp=sharing
DLL	1	1	https://drive.google.com/file/d/1_QUBTddSfHSi2yXdnTZN4yv7LqDVKbGe/view?usp=sharing	https://drive.google.com/file/d/1GVAr0q6WoYPJZWKAmSSuDqTM55n7-wY3/view?usp=sharing
EMR	1	1	https://drive.google.com/file/d/1AREN7g1BU0O6tXxkfiXeMQOGb74abdHm/view?usp=sharing	https://drive.google.com/file/d/1XHC6YodWiTpNDlr9YzDT8xZ8edRaQT4G/view?usp=sharing
MEFS	2	0	https://drive.google.com/file/d/1IDxNPCpGELh8svQosjz6jVPk0LfG1LOB/view?usp=sharing	https://drive.google.com/file/d/1csKDV9pc7_VKlxRVljq7yjL28YI26hsj/view?usp=sharing
NOR	2	0	https://drive.google.com/file/d/1cVBjiLVeaaLqJt4-qE0EWT_tBeuFKpOa/view?usp=sharing	https://drive.google.com/file/d/1v79SJ-8vZz-ly1nnZpHnj3DDS4T4uF6G/view?usp=sharing
MIRS	1	1	https://drive.google.com/file/d/1npyKfxp2Oif8qmO3C9ZbLF2VoyVbexSd/view?usp=sharing	https://drive.google.com/file/d/18ViXNJhzlWUOQSLy1DVtGIv7wn0aeMtj/view?usp=sharing
MSE	0	0	https://drive.google.com/file/d/1ZXRM8tMICBfPAO1h7lVJEf79AqDE4j1W/view?usp=sharing	https://drive.google.com/file/d/1ocXEIO5NCZvZTVpouFCHE8aFjxM_-rwQ/view?usp=sharing
MVBS	1	0	https://drive.google.com/file/d/1H2IidLyyBRSAhj_Um-j9tfoL_O6JlrTt/view?usp=sharing	https://drive.google.com/file/d/1WNhku_312htkX0iVwc28jYZGGXdoI0no/view?usp=sharing
	11	4		

The comparison of Best Moment (BM) clinical video scores between Phases 1 and 2 showed a 36.4% improvement. This result provides strong evidence of clinical recovery based on key markers, achieved after just one month of constitutional homeopathic treatment. The video assessments for these 9 out of 35 volunteers were independently conducted by the principal investigator.

Table – V: Example of Daily Reduction in Allopathic Medication Doses

Date	Confounding	Symptom	CH	OT	Average	WM	WM Hours	BM	BM Hours
11/07/2024	None	Parkinson	12	DNA 12+ ATP CH12	1.63	4	6	0	10
13/07/2024	None	Parkinson	12	No Repeat	1.21	4	6	0	11
18/07/2024	None	Parkinson	12	No Repeat	1.32	4	6	0	11
31/07/2024	lack of energy	Parkinson	12	No Repeat	1.79	4	7	0	10
08/08/2024		Parkinson	12	No Repeat	1.74	4	6	0	10

Video Example – Clinical Evolution

- **Baseline (July 13, 2024):**
  Best Moment (BM = 0): 11 hours/day
- https://youtube.com/shorts/hUFEQ3xyXl8
- (walking)
- Worst Moment (WM = 4): 6 hours/day
  Average clinical score: 1.21 over 17 waking hours
- https://youtube.com/shorts/sooKxV0z2Po
- (being loaded)

This patient—who was also receiving concurrent cancer therapy—gained one additional symptom-free hour daily (BM = 0) and reduced intense symptoms (WM = 4) from six to one hour/17 walking hours. Because the Veredas Protocol directs dose administration only during the worst-symptom period, the improvement allowed a proportional decrease in daily allopathic Parkinson's doses, from six to one.

This is a video that shows the action of the Veredas Protocol by reducing the number of times taken from 10 comp/day of Prolopa 125/50mg to 5 comp/day, along with improvements in gait from score 4 to score 2 in just 2 days.

VIDEO explaining individualized ideal dose in the Veredas Application.
https://youtu.be/7MyH0vFvPhE

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Observed Improvements Across the Cohort

Phase 2 results (Table 2) corroborate this pattern. In a condition typically marked by stability or progressive decline, most patients shifted from severe WM scores (3–4) in Phase 1 to mild scores (0–2) after only one month of homeopathy. Although formal significance testing was not feasible due to the small sample and short observation period, cross-referenced video analyses—independently rated by the principal investigator for 9 of the 35 volunteers—showed visible functional gains in motor performance even when numerical score changes were modest.

These qualitative findings strengthen the evidence that individualized, DE100-guided dosing can rapidly attenuate peak symptom intensity in Parkinson's disease, enabling tapering of conventional medication while improving overall clinical status.

Comparison with Previous Quantitative Studies

The clinical improvements observed in Phase 2 of this qualitative study are consistent with findings from earlier quantitative research, particularly when Organotherapeutics (OT) were added to Constitutional Medication (CM):

Quantitative Study 2 (2021, n = 41)[23]

- Overall symptom improvement: 91% (95% CI: 60–98%)
- Emotional/mental improvement: 85% (95% CI: 53–96%)
- Symptom-specific reductions over 30 days:
    - Difficulty swallowing: –18% (p = 0.000)
    - Tremors: –3% (p = 0.013)
    - Joint pain/locking: –8% (p = 0.000)
    - Speech difficulty: –7% (p = 0.008)
    - Gait/postural instability: –5% (p = 0.005)
    - Cognitive comprehension: –9% (p = 0.015)
    - Emotional symptoms: –10% average (p = 0.000)

Conclusion: Patients showed marked clinical improvement without suppression of symptoms — particularly evidenced by parallel improvements in emotional and cognitive domains.

Quantitative Study 3 (2012, n = 168)[24]

- Population: Parkinson's patients with chronic pain
- Phase 1 (Days 0–90):
    - 60.78% (78/129) achieved ≥50% reduction in McGill pain scores using only CM
- Phase 2 (Days 90–150):
    - Remaining 39.53% (51/129) received two additional CM doses plus one OT dose
    - Result: 49.2% additional pain reduction (p = 0.005)
    - Total improvement: 60.2% (p < 0.001)

Similarities and Differences Between Studies

- Both quantitative studies used an initial phase with CM and introduced OT later.
- The 2021 study extended follow-up to 550 days and aligned treatment adjustments with Worst Moment (WM) scores using the Veredas App.
- In both studies, clinical improvement and WM reduction supported the progressive tapering of allopathic medications.

Other Results

Advances in Homeopathic Prescription Practices

1. The study introduced the prescription of seven different doses (one every four days), instead of the conventional protocol of increasing the dose every 60 days. Identifying the best dose in just 28 days has brought benefits: A single dose above CH30 had an average effect of 60 to 90 days. The criterion of Effective Dose 100 allowed the dose to be repeated only when the previous dose lost efficacy. Treatment time was reduced by up to 15 times (28 days vs. 420 days). Average recommended dose: CH15.
2. Impact on Treatment Duration and Best Dose Identification Patients recorded symptoms for 15.3 hours a day (out of 18 hours awake). Before the study, they used only allopathic medicines for about 60.3 months. After the introduction of constitutional homeopathy, they were followed for only one month.
3. Discussion of Results Monitoring: monthly follow-up for 2 months; patients in stages I to IV of the disease. Randomization: abandoned due to the need to observe the isolated effects of the constitutional drug (CM). In the 3rd month of the default survey in the design planning, it was not possible to analyze test and placebo groups separately because both had already been previously remedied with their constitutional remedies and it would not be possible to evaluate the brain organotherapeutic method additionally because the homeopathic paradigm does not admit its use in isolation from the Constitutional Remedy that treats the patient as a whole. Data reliability: records in spreadsheets showed consistency, with mathematical synthesis made by the Veredas app. Videos: reinforced the reliability of the results by correlating clinical observations with evolutionary images. Identification of the Best Dose: the ideal dose was defined as the one prior to the one that caused worsening of symptoms. Veredas Protocol: proved to be innovative in quickly individualizing the ideal dose, optimizing therapeutic response and avoiding adverse effects.
4. Limitations of the Allopathic Approach UPDRS: although useful for assessing disease progression, it does not consider individualization of doses, which can induce overdose. Scheduling control: lack of detailed control of the Worst (WM) and Best (BM) moments can compromise the reliability of the data and delay therapeutic adjustments. Although it was not the scope of this study, we believe that the conceptual change of the Effective Dose 50 would bring to allopathy the beneficial effects brought by this work in the use of homeopathic medicines with the Hahnemanean Effective Dose 100 criterion.

CONCLUSION

We did not conclude only from the qualitative and quantitative results of the study. We can assume with great probability that the failures in allopathic or homeopathic treatments, which were submitted to the Veredas Protocol, compared to the Protocol of conventional allopathic prescriptions at fixed intervals of doses, are not due to the

medication but to the inadequate protocol of administration of the doses, in both paradigms. This is not only true for cerebrodegenerative diseases, but for any other diagnosis, allopathic or homeopathic.

The Veredas Protocol demonstrated itself as an innovative and efficient strategy for the individualization of homeopathic doses, offering a faster and more precise method for identifying the optimal dose. Its capacity to integrate temporal and variable aspects of Parkinson's symptoms highlights its potential for personalized treatment in complex clinical contexts.

This study opens the door to an urgent conversation aligned with recent and important investigations on dose-response testing methodologies, especially in silico simulations. These advances are even more relevant when compared to the limitations of conventional protocols based on the Effective Dose 50 (ED50), predominantly used by the pharmaceutical industry. By contrast, the Veredas Protocol adopts the conceptual foundation of Effective Dose 100 (DE100), a principle formulated by German physician and chemist Samuel Hahnemann in the 19th century. Remarkably, scientific proposals from that period, such as DE100, are only now beginning to gain recognition in contemporary research.

This work may represent a pioneering step toward re-evaluating the conceptual criterion of dose-response testing. It challenges the prevailing ED50 standard, which may be contributing to a global scenario where over 50% of patients relying on allopathic medicine are at risk of hospitalizations or even death due to serious adverse drug effects. The study thus calls for a renewed scientific discussion on the fundamental assumptions of pharmacological dosing and therapeutic safety.

Conflicts of Interest

None declared.

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