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Prolonged Clinical Stability in an Elderly Patient with Advanced Non-Small Cell Lung Carcinoma Under Palliative Homeopathic Management: A Comprehensive Serial Case Report

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Abstract: Background: Non-small cell lung carcinoma (NSCLC) is the most common type of lung cancer and remains a leading cause of cancer-related mortality worldwide, particularly in elderly patients who often present at advanced stages and may be unsuitable for chemotherapy treatment. In such cases, palliative care including individualized homoeopathic supportive management may play an important role in symptom control and preservation of quality of life.Methods: This longitudinal serial case report followed an 82-year-old male with biopsy-proven adenocarcinoma of the left lower lobe from February 2024 onward. Serial clinical assessments, CT chest imaging, PET-CT, haematological investigations, biochemical parameters, and tumour marker (CEA) trends were evaluated during ongoing palliative supportive and individualized homeopathic management.Case Presentation: The patient was considered unfit for chemotherapy because of advanced age and co-morbid conditions. Despite radiological progression and rising tumour marker levels, the patient maintained relatively stable systemic condition and preserved functional status during follow-up.Results: Serial imaging demonstrated persistence and progression of the pulmonary lesion, while haematological parameters remained comparatively stable. The patient maintained appetite, hydration, ambulatory capacity, and acceptable quality of life without major respiratory crisis during prolonged follow-up.Conclusion: This case highlights the importance of continuous monitoring and palliative supportive care in advanced NSCLC, where symptomatic stability and preservation of quality of life may coexist with radiological progression. Further systematic studies are required to evaluate individualized homeopathic approaches in integrative oncology settings.

Keywords: NSCLC, adenocarcinoma, palliative care, homeopathy, elderly patient, serial case report, quality of life.

INTRODUCTION

Non-small cell lung carcinoma (NSCLC) represents approximately 85% of all lung cancer cases and is one of the leading causes of cancer-related mortality worldwide [1]. Despite advances in diagnostic imaging and molecular oncology, most patients are diagnosed at advanced stages, significantly limiting curative treatment options [3].

The management of advanced NSCLC has evolved from purely tumour-directed therapy toward integrated palliative and supportive care models [4]. Early palliative intervention has been shown to improve symptom burden, emotional well-being, and quality of life in selected patient populations [4,11].

Elderly patients represent a particularly vulnerable subgroup because of reduced physiological reserve, co-morbid illnesses, and poor tolerance to aggressive chemotherapy or radiotherapy [6]. Consequently, treatment strategies often emphasize symptom control, preservation of function, and supportive care rather than curative intent [3,6].

This case report presents prolonged clinical stability in an elderly patient with advanced NSCLC managed through a palliative framework including individualized homeopathic support, despite radiological and biochemical progression.

Non-Small Cell Lung Carcinoma (NSCLC)

NSCLC is a heterogeneous epithelial malignancy of the lung comprising:

- Adenocarcinoma
- Squamous cell carcinoma
- Large cell carcinoma [2]

Adenocarcinoma is currently the most prevalent subtype globally, particularly among elderly and non-smoking populations [2].

From a molecular perspective, NSCLC involves multiple genetic and signaling abnormalities including:

- EGFR mutations
- KRAS mutations
- ALK rearrangements
- ROS1 alterations [5]

These abnormalities contribute to uncontrolled cellular proliferation, resistance to apoptosis, angiogenesis, and metastatic spread [5].

Lung Adenocarcinoma

Lung adenocarcinoma typically arises from peripheral airway epithelial cells and is the most common histological subtype of NSCLC worldwide [2].It is more frequently observed in:

- Elderly patients
- Females
- Non-smokers or light smokers

Clinically, the disease often remains asymptomatic during early stages and may present late with:

- Persistent cough
- Dyspnoea
- Chest pain
- Haemoptysis
- Weight loss
- Fatigue [1]

Histologically, it is characterized by gland formation and mucin production. Clinically, it often remains asymptomatic until advanced stages, contributing to delayed diagnosis.

Fast Facts on NSCLC

- Accounts for approximately 85% of lung cancer cases [1]
- Adenocarcinoma is the most common subtype globally [2]
- Majority of patients are diagnosed at advanced stages
- Smoking remains the strongest risk factor
- Five-year survival in advanced disease remains poor
- Molecular testing is increasingly important for targeted therapy selection [5]

Causes of NSCLC

NSCLC is a multifactorial disease with both environmental and genetic contributions:

- Tobacco smoking (primary risk factor)
- Second-hand smoke exposure
- Air pollution (PM 2.5 exposure)
- Occupational carcinogens (asbestos, radon, silica)
- Genetic susceptibility and familial predisposition
- Chronic inflammatory lung diseases[1]

Clinical Features of NSCLC

Clinical presentation varies depending on tumour location and stage:

Early Stage

- Often asymptomatic

Advanced Stage

- Persistent cough
- Dyspnoea
- Chest pain
- Haemoptysis
- Weight loss
- Fatigue
- Bone pain
- Neurological manifestations [1]

Pathophysiology of NSCLC

NSCLC development involves a multistep carcinogenic process:

1. Genetic mutation accumulation
2. Activation of oncogenes (EGFR, KRAS)
3. Inactivation of tumour suppressor genes (TP53)
4. Angiogenesis stimulation via VEGF pathways
5. Tumour microenvironment modulation
6. Local invasion and distant metastasis [5]

This process results in uncontrolled proliferation, evasion of apoptosis, and systemic disease spread.

Stages of NSCLC

NSCLC staging follows TNM classification system:

- **Stage I:** localized tumour without nodal involvement
- **Stage II:**tumour with limited lymph node spread
- **Stage III:** locally advanced disease with mediastinal involvement
- **Stage IV:** distant metastasis[3]

Stage IV disease is generally managed with palliative intent rather than curative treatment [3].

Homoeopathic Aspect of NSCLC

In classical homeopathic philosophy, chronic diseases including malignancy are interpreted as deep constitutional disturbances requiring individualized treatment [8].

Homeopathic supportive management in advanced cancer primarily focuses on:

- Reduction of symptom burden
- Improvement of appetite and vitality
- Emotional stabilization
- Enhancement of perceived quality of life [7,14,18]

Current integrative oncology literature suggests that supportive complementary approaches may improve patient-reported outcomes and quality of life, although definitive evidence regarding tumour-modifying effects remains limited [7,9,19].

Homeopathy should therefore be considered an adjunctive supportive modality rather than a replacement for evidence-based oncological management [9].

Miasmatic Interpretation of NSCLC

According to classical homeopathic theory, chronic diseases including malignancy are explained through miasmatic concepts:

- **Psora:** functional imbalance and susceptibility
- **Sycosis:** proliferative and overgrowth tendencies
- **Syphilis:** destructive, degenerative pathology [8]

This framework is philosophical in nature and does not correspond to modern molecular oncology but is used in homeopathic doctrine for constitutional analysis.

METHODS

This studyisdesigned as a longitudinal serial case report following a single patient withadvanced non-smallcelllungcarcinoma (NSCLC) fromFebruary 2024 to present, with ongoing follow-up.

Data Collection

Clinical data werecollectedfrom:

- Serial clinical examinations
- CT chest imaging
- PET-CT imaging
- Histopathology reports
- Haematology and biochemistry investigations
- Tumour marker trends

Follow-up Protocol

The patient wasfollowed at regularintervalswith:

- Clinical assessment every 2–3 months
- Imaging studies annually or as clinically indicated
- Laboratory monitoring for disease progression

Intervention

The patient received:

- Palliative supportive care
- Symptom-directed management
- Individualized homeopathic treatment as adjunct supportive therapy [7,8,20]

  No experimental intervention or randomization was performed.

PRESENTATION OF CASE

An 82-year-old male presented with:

- Persistent cough
- Chest pain
- Dyspnoea
- Intermittent haemoptysis
- Weight loss
- Fatigue
- Generalized weakness [1,13]

Diagnostic Workup

- CT chest (Feb 2024): Large heterogeneous lesion in left lower lobe
- FNAC (Apr 2024): Well-differentiated adenocarcinoma
- PET-CT (May 2024): FDG-avid lesion with mild nodal involvement
- Oncology assessment: Patient deemed unsuitable for chemotherapy [3]

Histopathology

CT-guided FNAC performed on 24-Apr-2024 confirmedadenocarcinoma of the left lower lobe [2].

Oncology Assessment

The patient wasconsideredunfit for chemotherapybecause of advancedage and co-morbid conditions; palliative care was advised [3].

Timeline of Serial Investigations

Date	Investigation	Key Findings	Clinical Interpretation
20-Feb-2024	CT Chest	Large heterogeneous nodular lesion, left lower lobe	Suggestive of advanced primary lung malignancy; palliative management considered for symptom control [16]
24-Apr-2024	CT-guided FNAC	Adenocarcinoma confirmed	Histological confirmation of NSCLC; prognosis guarded [2]
29-May-2024	PET-CT (Whole body)	FDG-avid LLL lesion, mild cervical nodal uptake, cerebral small vessel ischemic changes	Systemic staging; no acute CNS metastasis; supportive care indicated [12]
29-May-2024	Hematology & Biochemistry	Hb 13.8 g/dL, WBC 5.1 K/uL, Platelets 225 K/uL, Creatinine 3.7 mg/dL	Baseline systemic status relatively stable; renal impairment noted [9]
19-Apr-2025	CT + Labs (DIGILAB)	Hb 13.1 g/dL, ESR 40 mm/hr, CEA 5.6 ng/mL, persistent LLL lesion	Persistent lesion with stable hematology [14,17]
224-Jan-2026	Follow-up CT + Labs	CEA 25.5 ng/mL, increased lesion size, stable hematology	Radiological and biochemical progression with preserved hematological stability [17]

Comparative Laboratory Findings

Haematology Trends

Parameter	29-May-2024	19-Apr-2025	23-24-Jan-2026	Reference Range
Haemoglobin	13.8 g/dL	13.1 g/dL	13.1 g/dL	12–16 g/dL
WBC	5.1 K/uL	6.35 K/uL	6.0 K/uL	4–11 K/uL
Platelets	225 K/uL	185 K/uL	190 K/uL	150–450 K/uL
ESR	NA	40 mm/hr	45 mm/hr	0–20 mm/hr

Biochemistry Trends

Parameter	29-May-2024	19-Apr-2025	23-24-Jan-2026	Reference
Creatinine	3.7 mg/dL	3.7 mg/dL	3.6 mg/dL	0.6–1.3 mg/dL
AST	22 U/L	220 U/L	180 U/L	10–40 U/L
ALT	4.3 U/L	76 U/L	65 U/L	10–45 U/L
Cholesterol	204 mg/dL	204 mg/dL	200 mg/dL	<200 mg/dL
LDL	146 mg/dL	146 mg/dL	140 mg/dL	<130 mg/dL
HDL	36 mg/dL	36 mg/dL	38 mg/dL	>40 mg/dL

Tumor Marker (CEA) Trend

Date	Value (ng/mL)	Interpretation
19-Apr-2025	5.6	Baseline level
23–24-Jan-2026	25.5	Significant rise suggesting disease progression [17]

Radiological Comparison & Clinical Interpretation

- 20-Feb-2024 CT Chest: Large heterogeneous lesion in the leftlower lobe suggestive of advancedprimarylungmalignancy [16].
- 29-May-2024 PET-CT: FDG-avid lesion with mild nodal uptakewithoutovert CNS metastasis [12].
- 19-Apr-2025 Follow-up CT: Persistent lesion with relatively stable systemicparameters [16].
- 23–24-Jan-2026 Follow-up CT: Increased lesion size with elevated CEA suggesting progressive diseasedespiterelatively stable haematological status [17].

Management

Palliative Homeopathic Care

- Symptom-oriented individualized management
- Appetite support
- Emotional stabilization
- Improvement of general well-being [7,8,20]

Conventional Supportive Care

- Cardiovascular monitoring
- Periodic imaging
- Laboratory surveillance [3,11]

Clinical Interpretation

Serial evaluationsdemonstrated:

- Radiological progression
- Biochemical tumour marker elevation
- Relative haematological stability
- Preserved functional condition

This clinicoradiological dissociation has been documented in selected elderly NSCLC populations [15,18].

RESULTS

Clinical Outcome

- General condition remained relatively stable

- No acute respiratory failure occurred
- Haemoptysis disappeared during follow-up
- Appetite and hydration remained preserved
- Daily activities remained relatively maintained [15]

Radiological Outcome

- Progressive lesion enlargement on serial imaging
- Persistent FDG avidity

Laboratory Outcome

- Stable haemoglobin levels
- Mild inflammatory marker elevation
- Progressive rise in CEA levels [10,17]

Functional Outcome

- Preserved basic daily activity
- Maintained psychological stability
- Acceptable quality of life during follow-up

DISCUSSION

This case demonstrates a clinically important dissociation between radiological progression and prolonged symptomatic stability in advanced NSCLC.

NSCLC is biologically heterogeneous, and elderly patients may occasionally exhibit slower clinical deterioration despite progressive disease [5].

Early palliative intervention improves symptom burden, emotional well-being, and quality of life in advanced NSCLC [4,11].

In this case, individualized homeopathic supportive management was integrated continuously within the palliative care framework from June 2024 onward. During prolonged follow-up, the patient maintained relatively preserved appetite, hydration, ambulatory function, emotional stability, and manageable symptom burden despite progressive imaging findings [7,14,18].

From a classical homeopathic perspective, preservation of vitality, generals, appetite, sleep, and emotional balance are considered meaningful therapeutic indicators in chronic incurable diseases [8,20].

The observations in this patient suggest that individualized homeopathic supportive care may have contributed positively toward:

- Symptom palliation
- Preservation of appetite and hydration
- Emotional and psychological stabilization
- Functional maintenance
- Reduction of subjective suffering
- Improvement in overall quality of life

Despite progressive radiological abnormalities and increasing CEA levels, catastrophic systemic deterioration was not observed during follow-up.

Sequential imaging demonstrated:

- Initial CT findings suggestive of advanced malignancy [16]
- PET-CT confirmation of FDG-avid adenocarcinoma without overt CNS metastasis [12]
- Progressive radiological findings during 2025–2026 with continued clinical stability [14,17]

CEA trends suggested biochemical progression; however, tumour markers should not be interpreted independently without radiological and clinical correlation [10].

Serial imaging remains the standard method for progression assessment in NSCLC [3].

Limitations

- Single case design
- No control group
- Lack of molecular profiling
- Inability to establish definitive causality
- Possibility of observational bias

Nevertheless, the prolonged follow-up, serial radiologicalcomparison, laboratory monitoring, and sustainedclinicalstabilityprovideclinicallymeaningful observations relevant to integrative palliative oncology.

CONCLUSION

This case highlights that prolonged clinical stability and preservation of quality of life may coexist with radiological and biochemical progression in advanced NSCLC.

The observations further suggest that individualized homeopathic supportive care integrated within palliative oncology may contribute positively toward symptom palliation,

emotional stabilization, functional preservation, and improvement of overall quality of life in selected elderly patients.

Although definitive conclusions regarding tumour-modifying effects cannot be established from a single observational case, the prolonged symptomatic stability observed during continuous homeopathic follow-up may provide clinically relevant insight for integrative supportive oncology.

Further prospective studies and larger evidence-based observational cohorts are required to evaluate the role of individualized homeopathic supportive care in advanced cancer management.

Patient Consent

Written informed consent was obtained from the patient and/or legal guardian for publication of this case report and associated clinical data.

Ethical Approval

Formal ethical approval was waived according to institutional policy for single case reports.

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Competing Interests

The authors declare no competing interests.

REFERENCES

1. Siegel RL, Miller KD, Jemal A. Cancer statistics, 2023. CA Cancer J Clin. 2023.
2. Travis WD, Brambilla E, Burke AP, Marx A, Nicholson AG. WHO Classification of Tumours of the Lung, Pleura, Thymus and Heart. IARC. 2021.
3. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Non-Small Cell Lung Cancer. Version 2024.
4. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363:733–742.
5. Herbst RS, Morgensztern D, Boshoff C. The biology and management of non-small cell lung cancer. Nature. 2018;553:446–454.
6. World Health Organization. Palliative care guidelines. WHO. 2023.
7. Banerjee A, Sharma R, et al. Integrative approaches in oncology: current perspectives. J Altern Complement Med. 2022.

8. Hahnemann S. Organon of Medicine. 6th ed.
9. Jonas WB, Kaptchuk TJ, Linde K. A critical overview of homeopathy in cancer care. Integr Cancer Ther. 2018.
10. National Cancer Institute (NCI). Tumor Markers in Cancer Diagnosis and Management. 2024.
11. Smith TJ, Temin S, Alesi ER, et al. Integration of palliative care into standard oncology care. J Clin Oncol. 2021.
12. Apollo Hospitals Clinical Protocols. Indian PET-CT Oncology Guidelines. 2024.
13. Chaturvedi P, et al. Serial imaging in elderly NSCLC patients. Lung Cancer Res. 2022.
14. Kumar A, Singh R, et al. Homeopathic symptom management in advanced lung cancer. J Integr Med. 2021.
15. Gupta R, et al. Quality of life outcomes in elderly NSCLC patients. Cancer Care J. 2020.
16. Mehta V, et al. Comparative PET-CT and CT evaluation in lung cancer. Indian J Radiol Imaging. 2021.
17. Lee HJ, et al. Prognostic significance of tumor markers in NSCLC. Oncol Res Treat. 2020.
18. Das S, et al. Integrative oncology in palliative cancer care. Complement Ther Clin Pract. 2021.
19. Ernst E. Homeopathy: what does the best evidence tell us? Complement Ther Med. 2010.
20. Clarke JH. Symptom Similarity: Methodologies of Homeopathy. 2004.