

ROLE OF HOMOEOPATHY IN IRRITABLE BOWEL SYNDROME

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ABSTRACT

Irritable Bowel Syndrome (IBS) is characterized by recurrent abdominal pain and discomfort with altered bowel habits. It affects approx. 20% population across the world, among which only around 10% takes medical consultation for it. Its pathology is not clear but many factors seem to play role in this pathology. Its diagnosis is based on clinical findings and ROME criteria is widely used for the diagnosis. IBS has multiple complications and affects quality of life. Its treatment includes change in dietary habits, psychological counselling, exercise etc. Homoeopathy is widely accepted mode of treatment based on totality of symptoms and individualization and is able to cure IBS.

KEYWORDS- Irritable Bowel Syndrome, Diarrhoea, Constipation, GIT Disorder, Homoeopathy.

INTRODUCTION

Irritable bowel syndrome (IBS) is characterised by recurrent abdominal pain in association with abnormal defecation in the absence of a structural abnormality of the gut. ^[1] Irritable bowel syndrome (IBS) is a chronic and debilitating functional gastrointestinal disorder that affects 9%-23% of the population across the world. ^[2] About 10–15% of the population are affected at some time but only 10% of these consult their doctors because of symptoms. ^[1] Among this population most studies show a female predominance. The main cause of disease is not entirely apparent as various factors play key roles in its aetiology. ^[3] Although gains have been made in understanding the patho-physiology of IBS, exact mechanisms leading to symptom development are not completely understood. ^[4] No clear diagnostic markers exist for IBS; thus the diagnosis of the disorder is based on clinical presentation. ^[5] Its diagnosis is made according to a symptom-based classification system, the Rome Criteria, with the latest version, Rome IV. ^[4] IBS is not a fatal disease but it does greatly reduce quality of life. ^[6] Across the IBS subtypes, the presentation of symptoms may vary among patients and change over time. Patients report the most distressing symptoms to be abdominal pain, straining, myalgia, urgency, bloating and feelings of serious illness. The complexity and diversity of IBS presentation makes treatment difficult. ^[2] IBS has high comorbidity rates, reduces the quality of life, and causes negative impact on the monetary resources of both patients and society. In modern medicine despite the substantial cost of IBS to both patients and society, curative, medical interventions have yet to be discovered. The development and

persistence of IBS symptoms have been acknowledged as multi-factorial in nature, making treatment of the disorder a complicated, clinical endeavour. Approaches are based on the reduction of patient symptomatology, and current pharmacological management often provides suboptimal relief^[4] IBS has high comorbidity rates, reduces the quality of life, and causes negative impact on the monetary resources of both patients and society.

Homoeopathy is a therapeutic system of medicine based on the principle, “*Similia Similibus Curentur*” or ‘likes cured by likes’. It is a method of treatment for treating the patient by medicines that possess the power of producing similar symptoms in a healthy human being simulating the natural disease, which it can cure in the diseased person. In homoeopathy, individualization is done and for this purpose physical symptoms as well as psyche symptoms. Homoeopathy is a system which does not treat the disease but treats the patient and has been proved effective in treatment of IBS and is able to not just relieve but to cure the patient.

EPIDEMIOLOGY

Population-based studies estimate the prevalence of irritable bowel syndrome (IBS) at 10%-20% and the incidence of irritable bowel syndrome at 1%-2% per year.^[7] A meta-analysis shows a pooled estimate of international IBS prevalence of 11.2% with variation by geographic region; the lowest occurring in South Asia and the highest in South America. The prevalence is known to be higher in Western countries as compared to Asian countries. The prevalence of IBS within the community is between 10% and 25%. the ratio of females to males in India reversed, i.e. 1:3 to that of the Western countries. The disorder is usually found in the age group of 15–50 years and may also occur in children and elderly.^[8]

In a study, prevalence of IBS in India was seen in 12.27% of the study population with male-to-female ratio of 1.44:1. The prevalence rates of IBS was maximum in 45–50 years age group. The prevalence rates of IBS was in lower economic class (Kuppuswamy's scale). There was no significant association of IBS with socioeconomic status, educational status, marital status, or religion.^[8]

IBS is classified into four subtypes according to predominant stool consistency:^[6]

1. IBS with constipation (IBS-C);
2. IBS with Diarrhoea (IBS-D);
3. Mixed IBS (IBS-M); and
4. Unsubtyped IBS (IBS-U).

AETIOLOGY

- Genetic factors
- Infection and trauma
- Colonic motility
- Increased sensitivity to food

RISK FACTORS OF IBS

- Physical and psychological stress
- Smoking
- Frequent alcohol consumption

PATHOPHYSIOLOGY

IBS is recognized as a multi-factorial disorder, with the following among the proposed mechanisms contributing to symptomatology: gastrointestinal dysmotility, inflammation, visceral hypersensitivity,

and altered intestinal microbiota. [4] IBS has been conceptualized as a condition of visceral hypersensitivity (leading to abdominal discomfort or pain) and gastrointestinal motor disturbances (leading to Diarrhoea or constipation). Some have suggested that these abnormalities are secondary to psychological disturbances rather than being of primary relevance. [3]

1. Gastrointestinal Motor Abnormalities- Studies of colonic myoelectrical and motor activity under unstimulated conditions have not shown consistent abnormalities in IBS. In contrast, colonic motor abnormalities are more prominent under stimulated conditions in IBS. IBS patients may exhibit increased recto-sigmoid motor activity for up to 3 h after eating. [5]

2. Central Neural Dysregulation And Brain-Gut Interaction- Psychosocial factors appear to be important in IBS, although whether these factors directly alter gastrointestinal function remains uncertain. It is also possible that gastrointestinal dysfunction modulates central processes too. [2]

3. Visceral Hypersensitivity: IBS patients frequently exhibit exaggerated sensory responses to visceral stimulation. The frequency of perceptions of food intolerance is at least twofold more common than in the general population. [5]

4. Abnormal Psychological Features- The amygdala located in the CNS is known as an important structure active in the response to anxiety. This center activates the hypothalamic-pituitary-adrenal (HPA) axis and the autonomic system when patients find themselves in anxious situations. Chronic anxiety increases the activity of the amygdala leading to the formation of an HPA axis which will ultimately cause induced visceral hyperalgesia. [3] Most of the patients demonstrates exaggerated symptoms in response to visceral distension, and this abnormality persists even after exclusion of psychological factors. Psychological factors influence pain thresholds in IBS patients, as stress alters sensory thresholds. An association between prior sexual or physical abuse and development of IBS has been reported. [5]

5. Post-Infectious IBS- IBS may be induced by GI infection. Approximately 1 in ten patients with IBS believe their IBS began with an infectious illness. [2] Between 3 and 35% of patients assessed progress on to develop IBS symptoms three to twelve months after suffering from GI infections. [3]

6. Immune Activation and Mucosal Inflammation- Some patients with IBS display persistent signs of low-grade mucosal inflammation with activated lymphocytes, mast cells, and enhanced expression of pro-inflammatory cytokines. These abnormalities may contribute to abnormal epithelial secretion and visceral hypersensitivity. [5] Exposure to intestinal infection induces persistent low-grade systemic and mucosal inflammation, which is characterized by an altered population of circulating cells, mucosal infiltration of immune cells and increased production of various cytokines in IBS patients. [2]

Bio psychosocial factors are thought to play an important role along with luminal factors such as diet and micro biota. [5]

7. Altered Gut Flora- A high prevalence of small intestinal bacterial overgrowth in IBS patients has been noted based on positive lactulose hydrogen breath test. [5] Changes in the quantity and quality of bacteria present can convey selective effects on sensory-motor dysfunctions which can be influenced through bile acid malabsorption, mucosal irritation and inflammation, increased food fermentation and gas production. Increased faecal numbers of *Lactobacilli*, *coliform* and *Bifidobacteria* have been reported in patients affected by IBS. [3]

CLINICAL MANIFESTATIONS

Both GI and extra-intestinal complaints are included with the primary symptoms of chronic abdominal pain and altered bowel habits.

Chronic Abdominal Pain:

According to the current IBS diagnostic criteria, abdominal pain or discomfort is a prerequisite clinical feature of IBS. [5] Abdominal pain is usually described as a sensation of cramps of varying intensity along with periodic exacerbations. The pain is usually located in the lower abdomen, often felt in the lower left quadrant. [3]

Altered Bowel Habits:

Patients suffering with IBS often complain of altered bowel habits; this can be observed in the volume, frequency and consistency of the patient's stools. [3] Alteration in bowel habits is the most consistent clinical feature in IBS. The most common pattern is constipation alternating with Diarrhoea, usually with one of these symptoms predominating. At first, constipation may be episodic, but eventually it becomes continuous and increasingly intractable to treatment with laxatives. [5]

Diarrhoea:

Diarrhoea is usually characterized as frequent loose stools of small to moderate volume. Stools generally occur during the hours in which patients are awake; frequently in the morning or after mealtimes. Most bowel movements are preceded by lower abdominal cramps (tenesmus), urgency to defecate and often fecal incontinence is perceived which may be followed by a feeling of incomplete defecation. Approximately half of all patients suffering with IBS complain of a mucosal discharge occurring along with their stools. [3] Bleeding is not a feature of IBS unless haemorrhoids are present, and malabsorption or weight loss does not occur. [5]

Constipation:

Stools are usually hard with narrowed calibre, possibly reflecting excessive dehydration caused by prolonged colonic retention and spasm. [5] Patients may experience a sense of incomplete evacuation occurring even when the rectum is completely empty. This can lead to long periods of time spent in the bathroom. [3]

Gas and Flatulence:

Patients with IBS frequently complaints of abdominal distension and increased belching or flatulence, all of which they attribute to increased gas. [5]

Upper GI Symptoms: Between 25 and 50% of patients with IBS complaints of dyspepsia, heartburn, nausea, and vomiting. Prolonged ambulant recordings of small-bowel motility in patients with IBS show a high incidence of abnormalities in the small bowel during the diurnal (waking) period.

Extra-Intestinal Symptoms:

These include impaired sexual function, dysmenorrhea, dyspareunia and an increase in the frequency and urgency to urinate. Patients are more likely to suffer from hypertension, asthma or fibromyalgia.

DIAGNOSIS

Diagnosis is clinical in nature and investigations are performed to rule out other pathological conditions. Its diagnosis can be made confidently in most patients using Rome criteria combined with absence of alarm symptoms without complicated test. Full blood count and sigmoidoscopy should be undertaken in older patients (over 40 years). Endoscopic examination is required in patients with bleeding per

rectum. Diagnostic procedures are performed to rule out coeliac disease, microscopic colitis, lactose intolerance, bile acid malabsorption etc.

Different diagnostic criteria have been evolved starting from Manning’s criteria to Kruis criteria to Rome IV criteria. Rome criteria is most accepted method for diagnosis of IBS. In 1980, The Rome I criteria was proposed by a working team as a new diagnostic guideline and upon use was found to be more valuable than previously established criteria followed by Rome II in 1999, then Rome III in 2006 and the recent one Rome IV in 2016.

	Manning	Rome I	Rome II	Rome III	Rome IV
Diagnostic Timeframe	Symptoms given below with no duration of symptoms with no number of symptoms described but a threshold of three positive is the most commonly used.	Abdominal pain or discomfort relieved with defecation, or associated with a change in stool frequency or consistency, with two or more of the following on at least 25% of occasions or days for 3 months	Abdominal discomfort or pain that has two of three features for 12 wk (need not be consecutive) in the last one year.	Abdominal pain or discomfort three days per month in the last 3 mo associated with two or more symptoms.	Abdominal pain on average at least 1 day per week during the previous 3 months that is associated with two or more of the following symptoms.
Chief Symptom	Abdominal pain relieved by defecation	Abdominal pain or discomfort	Abdominal pain or discomfort	Abdominal pain or discomfort	Abdominal pain
Associated Symptoms	<ul style="list-style-type: none"> • More frequent stools with onset of pain • Looser stools with onset of pain • Mucus per rectum • Feeling of incomplete emptying • Patient-reported visible abdominal distension 	<ul style="list-style-type: none"> • Altered stool frequency • Altered stool form • Altered stool passage • Passage of mucus • Bloating or distension 	<ul style="list-style-type: none"> • Relieved with defecation • Onset associated with a change in frequency of stool • Onset associated with a change in form of stool 	<ul style="list-style-type: none"> • Improvement with defecation. • Onset associated with change in the form of stool. • Onset associated with a change in the frequency of stool. 	<ul style="list-style-type: none"> • Related to defecation. • Associated with a change in the form of stool. • Associated with a change in the frequency of stool.

Table-1 Different Criteria Developed for Diagnosis of IBS ^[2] ^[4]

Additional Diagnostic Features and Alarming Features in IBS ^[1] - Features supporting diagnosis of IBD

- Symptoms > six months.
- Frequent consultation unexplained symptoms.
- Stress worsens symptoms.

Alarming Features-

- Age > 50 years male, gender.
- Weight loss
- Nocturnal symptoms
- Rectal bleeding
- Anaemia

MANAGEMENT

Most important steps are to make a diagnosis and reassure the diagnosed patients. Many patients are concerned about their disease that causes a cycle of anxiety leading to colonic symptoms which further heighten anxiety.

GENERAL MANAGEMENT

The goal of treatment interventions is to provide IBS patients with symptomatic relief; often this is attempted through the use of non-pharmacological interventions such as mind-body therapies, diet modification, exercise, and other complementary and alternative approaches. cognitive behavioural therapy, multi-component psychological therapy, dynamic psychotherapy, and hypnotherapy have been found beneficial. ^[4] Relaxation training may be beneficial for symptom improvement and appears to be at least as effective as standard pharmacological treatment. Acupuncture can cause physiological changes that affect various endogenous neurotransmitter systems and can help in IBS. ^[2]

Changes in dietary habits can be recommended. A reduction in inflammation in GI tract can be achieved by avoiding the consumption of inflammatory stimulants such as allergens or chemicals, namely benzoates, alcohol, methylxanthines and caffeine consumption that cause the release of inflammatory mediators. Patients should be educated on how best to consume their three daily meals, by partaking of non-processed and fresh foods that consist of whole grains, fibers and vitamins two or three times a day. People having both IBS and lactase deficiency should avoid dairy products. People with bloating and increased gas (flatulence) should try to avoid foods such as beans, onions, celery, carrots, raisins, bananas, apricots and plums. It is recommended that foods containing vinegar, mustard, ketchup and pickled foodstuffs not be consumed either They should avoid foods that trigger an onset of their symptoms, consume a minimum of high fat foods and take part in regular physical activity. ^[3]

ROLE OF HOMOEOPATHY IN IRRITABLE BOWEL SYNDROME

A homoeopathic physician considers the man as a whole. He considers the life as a trinity of body, mind and soul. Homeopathy is a system of therapeutics based on law of similars. “Like cures like” ‘Similia Similibus Curentur’. It is an universal law, where patient is prescribed a similimum on the basis of ‘Totality of Symptoms’. The disease is a reaction of the patient to unfavorable environment factors and that this reaction manifests through signs and symptoms the patterns of this reaction and the essence of these sign and symptoms gives totality of symptoms. [Anxiety] This totality of symptoms guides in selection of remedy for individual patient.

Some commonly indicated homoeopathic medicines in IBS are:

1. **Nux vomica** - Nausea in morning, after eating. Weight and pain in stomach with flatulence and pyrosis. Epigastrium is bloated with difficult belching of gas. Feeling of bruised soreness in abdomen wall. Spasmodic colic with desire for stool. Constipation with frequent ineffective

- urging.^[9] Alternate constipation and Diarrhoea, scanty stool with mucus.^[10] Frequent but ineffectual and anxious effort to evacuate (in infants) or sensation as if anus were contracted or closed. A constipated feeling, whatever the state of the bowels.^[11]
2. **Podophyllum** - Distended abdomen and emptiness, with sensation of weakness and sinking Gurgling in abdomen. Feels better by rubbing abdomen, heartburn, gagging or empty retching.^[9] Abdomen swelled almost to bursting. Bloating feeling with soreness, uneasiness which aggravates after stool. Rumbling in abdomen with colic. Awakened by violent pains in stomach and bowels.^[11]
 3. **Sulphur**- Sensation of burning in stomach. Weak, empty or faint feeling in stomach about 11.am. Diarrhoea after midnight which is painless. Driving out of bed early in morning, as if bowel are too weak to retain their contents. Constipation with hard, dry painful, large stool.^[10] Constipation with hard, knotty stool with insufficient evacuations. Frequent and often ineffectual want to evacuate, chiefly at night, and sometimes with pressure on rectum and bladder and pain in anus. Urgent want to evacuate. Looseness of bowels; redness about anus; obstructed evacuation, particularly if hard stools are retained.^[11]
 4. **Lycopodium**- Great weakness of digestion, bulimia with mucus bloating with rolling of flatulence. Wakes at night feels hungry, incomplete burning eructation. Eating ever so little created fullness.^[9] Excessive accumulation of flatulence, few mouthfuls upto throat and he feel bloated with gurgling and cracking.^[10] Constipation of long standing with hard stools with ineffectual desire to evacuate. Desire for stool followed by painful constriction of rectum or anus. Small stool, with the sensation as if much remained behind, followed by excessive and painful accumulations of flatulence. Haemorrhage from rectum, even after a soft stool. Feeling of fullness in rectum continues after a copious stool.^[11]
 5. **Naturm carbonicum** – Waterbrash, very weak digestion caused by slightest error of diet, feels swollen and sensitive averse to milk.^[9] Urgent want to evacuate, without result, or followed by a scanty and insufficient evacuation. Hard and difficult evacuation. Soft or liquid faeces, with strong and very urgent want to go to stool, and tenesmus ani. Loose, yellow evacuations. Diarrhoea which is marked by a sudden and obligatory call to stool, which escapes with great haste, noise, and rushing, often producing considerable commotion in abdomen.^[11]
 6. **Argentum nitricum** – Digestive upsets accompanied by nervousness and anxiety, Bloating, rumbling flatulence, nausea, and greenish Diarrhoea can be sudden and intense, Diarrhoea may come on immediately after drinking water, Eating too much sweet or salty food, expressive, impulsive, and claustrophobic, and may have blood sugar problems.^[9] Green, slimy, shreddy stools, with severe bearing-down in hypogastrium. Membranous stool like unsegmented tapeworm, blood, slime, and epithelium with much flatus, after eating sugar, after drinking "as soon as the least drink is taken it goes through".^[11]
 7. **Asafoetida**- Flatulence and regurgitation, hysterical flatulence, great distension, sensation of weakness and emptiness, forcible eructation of gas. Cutting and burning in stomach, gurgling and rolling of wind, violent gastralgia, pulsations in pit of stomach.^[9] Pain in perineum, as from something dull pressing out. Stool profuse, watery, or thick, brown, and exceedingly offensive. Diarrhoea, very offensive, with pain in the abdomen and discharge of fetid flatus. Stool stinking; slow; difficult; hard.^[11]
 8. **Colocynthis**- Agonizing cutting pain in abdomen causing patients to end over double and pressing on abdomen, intestine feels as if burst, colic with cramps in calves, pain in small spot below navel.^[9] Warm feeling followed by copious discharge of flatus. Colic with inflation in

umbilical region; colic below umbilicus. Irresistible inclination to stool; scanty brownish-red evacuation with painful tenesmus lasting ten minutes. ^[11]

9. **Pulsatilla-** Painful, distended; loud rumbling. Pressure as from a stone. Colic, with chilliness in evening. Rumbling in abdomen with watery; worse, night. No two stools alike. Two or three normal stools daily. ^[9] Thirstlessness with nearly all complaints; gastric difficulties from eating rich food, cake, pastry, especially after pork or sausage; the sight or even the thought of pork causes disgust. ^[10]
10. **Silicea-** Pain or painful cold feeling in abdomen, better external heat. Hard, bloated. Colic; cutting pain, with constipation; yellow hands and blue nails. Much rumbling in bowels. Great straining; rectum stings; closes upon stool. Faeces remain a long time in rectum. Constipation always before and during menses; with irritable sphincter ani. Diarrhoea of cadaverous odour. ^[9]

CONCLUSION

IBS is a functional disorder that has affected a large population and has caused a burden on patient as well as state. It causes recurrent abdominal pain and discomfort with altered bowel habit. It not only affects patient physically but also affects Quality of Life. Homoeopathy is a system which not only treats the disease but treats the patient as a whole and also helps in improvement of Quality of Life.

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