

Original Research Article**To Study the Efficacy of Homoeopathy in Management of Irritable Bowel Syndrome (IBS)**

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Abstract: Irritable Bowel Syndrome (IBS) is defined as a gastrointestinal (GI) disorder characterized by altered bowel habits and abdominal pain in the absence of detectable structural abnormality. (Ref. Harrison). IBS causes a great deal of discomfort and distress, but it does not permanently harm the intestines. Most people can control their symptoms with diet, stress management, and prescribed medications. For some people, however, IBS can be disabling. They may be unable to work, attend social events, or even travel short distances. 30 cases of IBS were studied satisfying the case definition. Inclusion and exclusion criteria were laid down. Assessment Criteria was laid down. Observations with respect to age, sex, occupation, remedies was done and efficacy of Homoeopathy was analysed in these cases. Homoeopathy is useful in treating cases of IBS.

Keywords: IBS, Structural Abnormality, Homoeopathy, Intestines

INTRODUCTION

Irritable bowel syndrome (IBS) is important because of its high prevalence, substantial morbidity and enormous costs.

IBS is characterized by the presence of abdominal discomfort or pain associated with disturbed defecation.

Bloating or visible abdominal distension often are present in patients with IBS but are not considered essential symptoms for diagnosis. It's now proposed with subsequent studies that the Rome criteria can be used in clinical practice with success.

Comparison of the Major Diagnostic Criteria for the Irritable Bowel Syndrome [1]

| Manning Criteria | Rome I Criteria | Rome II Criteria |
|---|--|--|
| <ul style="list-style-type: none"> Abdominal pain that is relieved after Bowel movement Looser stool at pain onset More frequent stool at pain onset Abdominal distention (Visible) Sensation of incomplete evacuation Passage of mucus | <p>More than or equal to 3 months of continuous or recurrent symptoms of abdominal pain or discomfort relieved with defecation or associated with change in frequency or consistency of stool and Disturbed defecation (more than or equal to 2 of the following): -</p> <ul style="list-style-type: none"> Altered stool frequency Altered stool form (hard or loose) Altered stool passage (straining or urgency, feeling of incomplete evacuation) Passage of mucus Bloating or feeling of Abdominal Distention | <p>More than or equal to 12 weeks, which need not be consecutive, in the preceding 12 months of abdominal discomfort or pain that has at least 2 of the 3 following features: -</p> <ul style="list-style-type: none"> Relieved with defecation Onset associated with change in frequency of stool Onset associated with a change in stool form |

Clinical Features [2, 3]**Abdominal discomfort or pain**

IBS should not be diagnosed in the absence of abdominal discomfort or pain. The pain or discomfort in IBS typically is relieved by defecation, or its onset is

associated with an increase or decrease in stool frequency or looser or harder stool. The pain often is poorly localized, waxes and wanes, may be aggravated after eating, and can occur in any part of the abdomen, although it more typically is located in the lower

abdomen; it may be referred to different areas in abdomen or to the chest or back. Exacerbation of pain by life event or difficult life situation is common. Abdominal discomfort or pain that is continuous or unrelated to defecation or induced by menstruation, urination or physical activity is unlikely to be caused by IBS.

Constipation or Diarrhea

Patients with IBS experiences constipation, diarrhea or alternating constipation or diarrhea; typically bowel symptoms are variable and intermittent. The term constipation and diarrhea may reflect a wide variety of different symptoms experiences to different patients, and so whenever patient uses them, an exploration of their meaning is required. Stool form can be measured objectively and graded by patient or physician; the Bristol stool form scale now is routinely used in clinical trials, and changes in stool form (at the extreme ends of the scale) roughly correlate with colonic transit time.

Bloating and Visible Distention

A feeling of bloating is common in IBS, and its site can be difficult for the patient to localize. Visible abdominal distention is characteristic but less common. Gas can mean excess bloating, belching, flatus, or even reflux symptoms to the patient. Again, it is important that patients are asked to explain the meaning of the terms they are using to describe their symptoms.

Non – colonic Symptoms

They themselves are not diagnostic. Nausea is common and at least one third of patients with IBS have epigastric discomfort or pain (dyspepsia). Extracolonic symptoms including headache, backache, impaired sleep, fatigue, increased urinary frequency or urgency, and dyspareunia are more common in patients with IBS but have no accepted diagnostic value. Comorbid anxiety or depression, and fibromyalgia also are associated with IBS.

Chronicity

For a confident diagnosis of IBS, symptoms should have been present for at least 6 months; IBS may accompany other chronic disorder. For example, IBS is present in one third or more patients with IBD in remission.

Physical Examination [4]

The physical examination in IBS usually is normal, although deep tenderness over the colon may be appreciated. Abdominal wall pain should be excluded clinically by Carnett's test.

Management [5, 6]

Education and support

IBS tends to be a life – long disorder, and establishment of a strong physician – patient relationship is a key to providing the best clinical care.

It is important to discover why patient has decided to visit at this time. The reason can vary: new life stressors; exacerbating factors in the diet or change in medication; increased fear of serious disease; and the development of treatable psychiatric comorbidity. In terms of providing optimal reassurance, it is important first to educate the patient and then to actively reassure them.

Diet

The standard of care for IBS typically has been a high fiber diet. Many patients with IBS suspect that food intolerance may be relevant to their symptoms. It is useful to determine the amounts of milk and milk products being consumed to decide whether lactose intolerance testing should be considered. If IBS symptoms persists despite withdrawal of all lactose in diet, indicating that this is the chance overlap of common condition. Excessive fructose can lead to IBS like symptoms that might be relieved by exclusion of this sugar. Reducing fatty food, gas producing food, or caffeine or alcohol also may be helpful in some patients.

Antispasmodics and Anticholinergics [7, 8]

In USA, Anticholinergics (dicyclomin, propanthelin, belladonna, and hyoscyamine) continue to be used commonly for IBS. Overall there was an improvement in pain and IBS global symptoms.

Laxatives

The efficacy of this class of drugs for constipation predominant IBS is uncertain. Osmotic laxatives often are prescribed but can aggravate bloating and pain. Stimulant laxatives are probably safer than has been appreciated, but they often induce abdominal cramping or pain and generally seem unsatisfactory for patients with IBS.

Antidiarrheals

Loperamide is established to be efficacious in controlling diarrhea but it this agent does not improve abdominal pain or bloating. Codeine phosphate because of its side effects (dizziness, nausea and sedation) and high risk of inducing dependency should be avoided in IBS.

Antidepressant and Anxiolytics

Miscellaneous Drugs

Three weeks of oral prednisone (30 mg/day) failed to improve post infectious IBS symptoms. Colchicine increases spontaneous bowel movements and decreases colonic transit time, but

its role in IBS with constipation is unknown. Octreotide reduces intestinal transit time, secretion and sensations in IBS.

Psychological Treatments

Psychotherapy, hypnotherapy, and cognitive behavioral therapy (CBT) have been proposed to be useful treatment for IBS. Psychological distress appear most likely to have a beneficial response to such intervention, particularly if the symptoms have been of short duration and have waxed and waned. Patients with constant abdominal pain do poorly with psychological treatment. The major advantage of psychological treatment is that despite the initial expense, long term benefits may be cost offsetting [9].

Alternative Treatments

Many different alternative remedies have been tried by patients but statistical efficacy of all needs to be proved.

Prognosis

In clinical practice, once a diagnosis of IBS has been made, it usually requires no revision despite prolonged follow up. Usually IBS is a relapsing disorder. The presence of excessive pathological distress or anxiety, as well as a long duration of complaints, tends to indicate a poorer prognosis.⁹

Aims and Objectives

Aim

To assess the efficacy of Homoeopathic Medicines in cases of IBS.

Objective

To study utility of Homoeopathy in IBS.

To reduce the

- Frequency
- Intensity
- Duration
- reduce recurrence in cases of IBS

MATERIALS AND METHODS

This study was conducted on patients coming to Author's OPD. A sample of 30 cases was taken. Diagnosis was mostly done clinically by using Manning's, Rome I and Rome II criteria. Patients

from all ages and both the sexes were studied. The data has been collected by a structured interview session.

Case definition

Irritable Bowel Syndrome is clinically defined as consisting of altered bowel habit, abdominal pain, and the absence of detectable organic pathology

Inclusion Criteria

All cases which fit into Manning's criteria and Rome's criteria

Exclusion Criteria

- Cases which doesn't fit into Manning's and Rome's criteria
- Cases with symptoms for less than 12 weeks
- Cases with abnormalities in lab investigations

Material

All the data was recorded in case format attached in appendix. Cases were analyzed and evaluated and repertorised with Synthesis Repertory RADAR 10.

Follow up chart was maintained to evaluate improvement in each case and is thus data of all cases is maintained.

Administration of Drug

The potency and repetition were strictly individualistic

Medicines were administered orally

Criteria for Assessment

- Relief of symptoms
- Patient in general
- Reduction in duration of attack
- Relief from reoccurrence

For an effective evaluation and assessment, disease intensity was graded in every patient based on their presentation observed during case taking. After completion of the study, the post treatment disease scores were compared with the pre treatment disease intensity scores and statistically evaluated using the "t-test".

Before treatment scoring is done as follows

| | |
|--|----------|
| Observable characters of stool | |
| (type, character, colour and consistency) | 3 |
| Symptoms | |
| (sensation of incomplete evacuation, pain as regards stools) | 2 |
| Mind | |
| (if directly available and prominent) | 4 |

After treatment scoring is done as follows

| | |
|--|----------|
| Amelioration in Observable characters of stool (type, character, colour and consistency) | 2 |
| Amelioration of Symptoms (sensation of incomplete evacuation, pain as regards stools) | 1 |
| Amelioration in Mind symptoms (if directly available and prominent) | 3 |

The evaluation of cases of IBS is based on the disease intensity scores before treatment and after treatment. The cases with intensity scores 0 (after treatment) are considered as IMPROVED and the cases with ‘Same’ or ‘Increased’ intensity scores after treatment are considered as NOT IMPROVED

Observation and Statistical Analysis

A sample of thirty cases from patients from the author’s OPD was taken for this study. All the thirty cases were followed up for a period of six months. These cases were subjected to statistical study. The following tables reveal the observation and result of this study.

Table-1. Distribution of cases according to their age

| Age (in years) | Number of cases | Percentage |
|----------------|-----------------|------------|
| 1 – 10 | 0 | 0% |
| 11 – 20 | 2 | 6.66% |
| 21 – 30 | 5 | 16.66% |
| 31 – 40 | 9 | 30% |
| 41 – 50 | 6 | 20% |
| 51 – 60 | 6 | 20% |
| 61 and above | 2 | 6.66% |
| Total | 30 | 100% |

The age of the sample varies from 16 – 65 years. Among this maximum number of cases 9 patients (30%) were noted in the age group of 31-40 years. In the age group of 41-50 and 51 – 60 years 6 (20%) cases.

The next incidence of age group is in 21-30 years with 5 patients (16.66%). This is followed by the age group 11- 10 years and 61 years and above with 2 patients (6.66%)



Fig-1: Diagrammatic representation of Age Incidence

Table-2: Distribution of cases according to their Sex

| Sex | Number of cases | Percentage |
|--------|-----------------|------------|
| Female | 20 | 66.67% |
| Male | 10 | 33.33% |
| Total | 30 | 100% |

In these thirty cases 10 patients were males with a percentage of 33.33% and 20 patients were females with a percentage of 66.67%. The male and

female ratio is 1:2. This again shows the female predominance in cases of IBS.

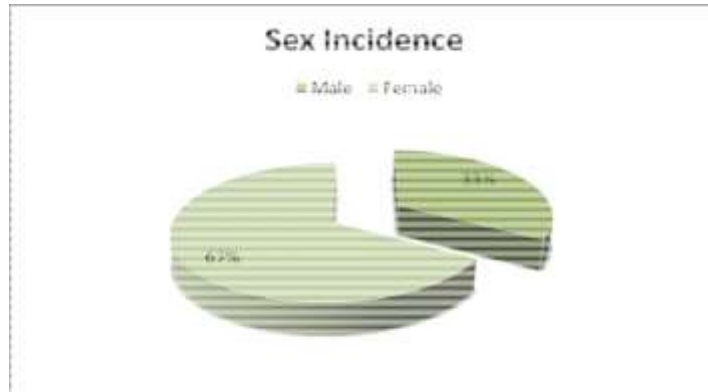


Fig-2: Diagrammatic representation of Sex Incidence

Table-3: Distribution of cases according to their Occupation

| Occupation | No. of Patients |
|--------------------|-----------------|
| Housewife | 11 |
| Job | 9 |
| Student | 3 |
| Engineer | 2 |
| Research assistant | 1 |
| Music arranger | 1 |
| Business | 1 |
| Maid | 1 |
| Mukadam | 1 |
| Total | 30 |

Surprising finding was that 11 out of 30 (36.66%) are housewives. Out of remaining

patients, 9 have sedentary life style because of job. 3 are students and 2 are engineers.

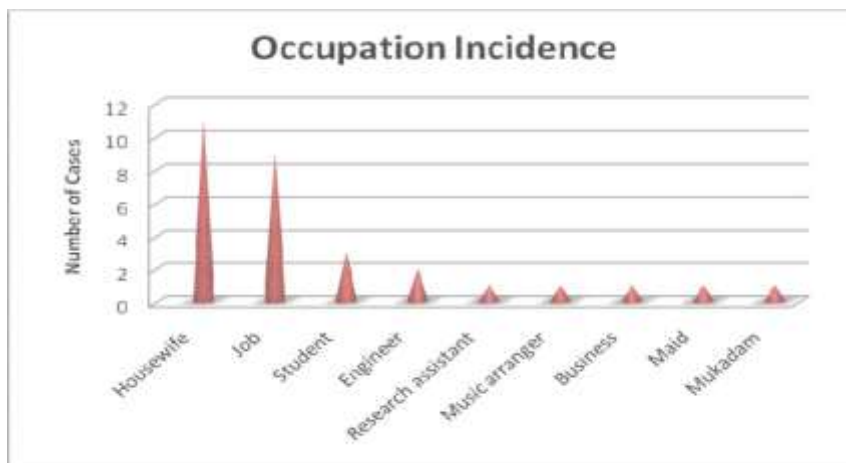


Fig-3: Diagrammatic representation of Occupational Incidence

Table-4: Distribution of cases according to predominant stool type

| IBS With | No. of Cases |
|-------------------------------------|--------------|
| Diarrhea | 16 |
| Constipation | 10 |
| Alternate diarrhea and constipation | 4 |

Out of 30 patients 16 (54%) showed predominant diarrhea, 10 (33%) showed predominant constipation and

remaining 4 (13%) showed alternate diarrhea and constipation

To assess the utility of Homoeopathy scoring was done for the symptoms shown before and after

treatment. Paired 'T' test was applied.

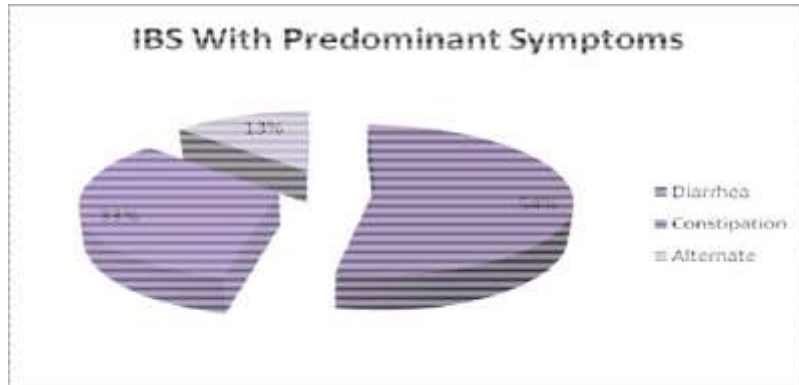


Fig-4: Diagrammatic representation of predominant stool type

Table-8: Scores before and after Homoeopathic treatment

| Case No. | X score | Y score | Z = X - Y | | |
|----------|---------|---------|-----------|------|-------|
| 1 | 6 | 0 | 6 | -4.1 | 16.81 |
| 2 | 18 | 0 | 18 | 7.9 | 62.41 |
| 3 | 17 | 0 | 17 | 6.9 | 47.61 |
| 4 | 12 | 8 | 4 | -6.1 | 37.21 |
| 5 | 12 | 0 | 12 | 1.9 | 3.61 |
| 6 | 12 | 3 | 9 | -1.1 | 1.21 |
| 7 | 14 | 0 | 14 | 3.9 | 15.21 |
| 8 | 11 | 4 | 7 | -3.1 | 9.61 |
| 9 | 15 | 2 | 13 | 2.9 | 8.41 |
| 10 | 15 | 0 | 15 | 4.9 | 24.01 |
| 11 | 18 | 0 | 18 | 7.9 | 62.41 |
| 12 | 8 | 0 | 8 | -2.1 | 4.41 |
| 13 | 11 | 3 | 8 | -2.1 | 4.41 |
| 14 | 16 | 0 | 16 | 5.9 | 34.81 |
| 15 | 13 | 3 | 10 | -0.1 | 0.01 |
| 16 | 8 | 1 | 7 | -3.1 | 9.61 |
| 17 | 12 | 0 | 12 | 1.9 | 3.61 |
| 18 | 13 | 8 | 5 | -5.1 | 26.01 |
| 19 | 15 | 3 | 12 | 1.9 | 3.61 |
| 20 | 15 | 0 | 15 | 4.9 | 24.01 |
| 21 | 12 | 0 | 12 | 1.9 | 3.61 |
| 22 | 15 | 0 | 15 | 4.9 | 24.01 |
| 23 | 15 | 10 | 5 | -5.1 | 26.01 |
| 24 | 11 | 7 | 4 | -6.1 | 37.21 |
| 25 | 8 | 5 | 3 | -7.1 | 50.41 |
| 26 | 12 | 0 | 12 | 1.9 | 3.61 |
| 27 | 8 | 0 | 8 | -2.1 | 4.41 |
| 28 | 9 | 2 | 7 | -3.1 | 9.61 |
| 29 | 6 | 0 | 6 | -4.1 | 16.81 |
| 30 | 15 | 10 | 5 | -5.1 | 26.01 |
| Total | 372 | 69 | 303 | | 600.7 |

\bar{x} = Standard error of the mean difference

Now the question is, 'Is there any difference between scoring before and after treatment?'

Null hypothesis: It appears that there is no difference in score in these cases after treatment

Standard error of mean differences –

$$Z = \frac{\sum Z}{n} = 303 / 30 = 10.1$$

$$S_z = \frac{\sum Z^2 - \frac{(\sum Z)^2}{n}}{n-1} = 24.5092 / 29 = 5.91$$

$$t = \frac{-}{S_{z/1-\alpha}} = 10.1 \times 5.4772 / 5.91 = 9.36$$

Comparison with tabled value

This critical ratio, t, follows a distribution with n-1 degrees of freedom. The table value at 5% level is

2.00 for 29 degree of freedom and the 1% level 2.60. The calculated value is 9.36. It is greater than the table value at 5% and 1% level. This means the probability (P) is greater than the table value. Therefore, the null hypothesis is rejected in this study

Table-9: Master Chart

| Sr. No. | Remedy | Relief of symptoms and in general | Interpretation |
|---------|------------|-----------------------------------|----------------|
| 1 | Sulphur | Relieved | Improved |
| 2 | Sepia | Relieved | Improved |
| 3 | Sulphur | Relieved | Improved |
| 4 | Nat carb | Not Relieved | Not Improved |
| 5 | Anacardium | Relieved | Improved |
| 6 | Ars Alb | Relieved | Improved |
| 7 | Nat Mur | Relieved | Improved |
| 8 | Sepia | Relieved | Improved |
| 9 | Arg. Nit. | Relieved | Improved |
| 10 | Silicea | Relieved | Improved |
| 11 | Mag – C | Relieved | Improved |
| 12 | Croton – T | Relieved | Improved |
| 13 | Bryo | Relieved | Improved |
| 14 | Nux – V | Relieved | Improved |
| 15 | Graph | Relieved | Improved |
| 16 | Gambogia | Relieved | Improved |
| 17 | Calc – C | Relieved | Improved |
| 18 | Aesculus | Not Relieved | Not Improved |
| 19 | Pulsatilla | Relieved | Improved |
| 20 | Gels | Relieved | Improved |
| 21 | Colo | Relieved | Improved |
| 22 | Podo | Relieved | Improved |
| 23 | Sulphur | Not Relieved | Not Improved |
| 24 | Nat – M | Not Relieved | Not Improved |
| 25 | Silicea | Not Relieved | Not Improved |
| 26 | Lycopodium | Relieved | Improved |
| 27 | Pulsatilla | Relieved | Improved |
| 28 | Pulsatilla | Relieved | Improved |
| 29 | Antim - C | Relieved | Improved |
| 30 | Nux - V | Not Relieved | Not Improved |

DISCUSSION

Cases of IBS were studied for the effectiveness of Homoeopathy. Even though IBS is a psycho – somatic disease, many times exact mental cause can't be elicited as most of these personalities are over anxious. They tend to misguide the intensity of their suffering and cause. It is really difficult for budding Homoeopaths to interpret mind or to find out the exact causative factor. Instead physicals seem easy to rely upon

Physical generals, modalities and concomitants are more dependable and easy to elicit .These symptoms seem to form the symptom complex of patients with IBS.

During this study following things are prominently noticed

Female predominance is known but out of these 20 females 11 were housewife. This again needs further statistical analysis.

Considering the age, in this 30 cases, youngest was 16 years and oldest was 65 years. As proved many times middle age group showed maximum number of patients.

Remedy indicated first time after case working improved patients in 80% of cases proving the utility of this approach with Synthesis Repertory.

In many cases remedy indicated was confirmed by mental symptoms as well as physical symptoms. E.g. in one case remedy was Graphites, it was confirmed with other observations like cracked skin, tendency to weep, etc.

Concomitants gave a great clue in selection of remedies in 3 cases.

Also as given in all books of gastroenterology counseling plays an important role. In case number 7 (R. S.), girl afterwards gave a history of recent disappointment in love and along with medicine counseling and meditation helped her in accepting the situation.

For very anxious patients Yoga also played a great role in relieving the stress bloating and dyspepsia and sometimes constipation too. But patient needed a convincing to follow such therapy.

Exclusion of certain diet food was advised to 2 patients for few days but after treatment they could eat those food articles which actually used to precipitate the complaints.

These things play an adjuvant role and help treat patient in a better way.

Thus cases of IBS can be managed by administering a similimum arrived at after careful repertorizing.

Summary and Conclusion

Total 30 cases were studied and followed for a minimum of 6 months. Data collected was subjected to statistical analysis. 't' test is applied for statistical analysis as n was less than 30.

The statistical analysis proves that Homoeopathy is significantly useful in these 30 cases of IBS. Out of 30 cases 24 cases i.e. 80% showed marked improvement in symptoms as well as reduction in duration and frequency of attack.

Along with medicine counseling, meditation, yoga and certain dietary regulations played an adjuvant and efficient role in management of patients.

Synthesis is like an ocean of rubrics with its ever increasing number of rubrics and remedy list. Finding out a appropriate rubric is easy as the structure of repertory has a kentan dominance. This repertory is very user friendly especially with its information booklet helps understand its utility. Also the option of index on word makes it easier for a beginner to get acquainted easily with the repertory. Also comparative

remedy extraction helps enhance the knowledge of Materia Medica.

Ultimate aim of all physicians should always be to help patient get rid of his suffering as early as possible in a gentle and permanent way. This aim can be achieved in different ways and which approach to choose is an individual choice.

For all beginners, Homoeopathy is easy as it is based on observable facts and not the interpretation. Interpretation can differ from person to person but modalities or observable concomitant of tongue or stool can't be changed. This builds up confidence in budding Homoeopaths to produce good results and treating even the chronic disorders in easy way.

Concluding this research with a line that –

“No matter what approach you use, what repertory you use when your understanding of the core of patient is clear, you are bound to reach a similimum.”

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REFERENCES

1. Peckham, E. J., Nelson, E. A., Greenhalgh, J., Cooper, K., Roberts, E. R., & Agrawal, A. (2013). Homeopathy for treatment of irritable bowel syndrome. *The Cochrane Library*.
2. Peckham, E. J., Relton, C., Raw, J., Walters, C., Thomas, K., & Smith, C. (2012). A protocol for a trial of homeopathic treatment for irritable bowel syndrome. *BMC complementary and alternative medicine*, 12(1), 212.
3. Peckham, E. J., Relton, C., Raw, J., Walters, C., Thomas, K., & Smith, C. (2012). A protocol for a trial of homeopathic treatment for irritable bowel syndrome. *BMC complementary and alternative medicine*, 12(1), 212.
4. Svedlund, J., Sjödin, I., & Dotevall, G. (1988). GSRS—a clinical rating scale for gastrointestinal symptoms in patients with irritable bowel syndrome and peptic ulcer disease. *Digestive diseases and sciences*, 33(2), 129-134.
5. Smart, H. L., Mayberry, J. F., & Atkinson, M. (1986). Alternative medicine consultations and remedies in

patients with the irritable bowel syndrome. *Gut*, 27(7), 826-828.

6. Harrison's principles of Internal Medicine – 17th edition
7. Davidson's principle and practice – 20th edition
8. Gastrointestinal diseases by Sleisenger and Fordtran – 8th edition
9. Google search