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HOMOEOPATHIC APPROACH IN THE MANAGEMENT OF IRRITABLE BOWEL SYNDROME.

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Abstract- irritable bowel syndrome is a most commonly diagnosed functional bowel disorder with high population prevalence worldwide. Patients with this disorder due to its periodical variation of symptoms from mild to severe are seen to have difficulty in day-to-day activities leading to increased work absenteeism and decreased work productivity thus affecting the overall quality of life of a person. This article aims to seek the scope of homoeopathy in the management of IBS. This article includes the prescription of specific remedy for characteristic, peculiar, striking symptoms of IBS.

Keywords- Rome IV criteria, homoeopathy, irritable bowel syndrome, FODMAP.

Introduction-

IBS symptoms are tended to be seen in ~10- 20% of adults and adolescent. It is a functional bowel disorder characterized by recurrent abdominal pain or discomfort along with variation in the bowel habits in absence of any structural abnormality of the gut. IBS accounts for frequent absenteeism from work and impaired quality of life. Young women are affected more often than men. Such patients have a plethora of non-colonic symptoms such as back pain, urinary frequency, and chronic fatigue. In addition, sleep disturbance and depressed mood are common in IBS patients. Diagnosis of IBS can be made using the Rome IV criteria (Drossman 2016), although this is largely a research tool used to allow common reporting standards of symptoms in trials and other research populations. In clinical practice the diagnosis of IBS is largely based on symptoms, although the presence of alarm symptoms (e.g. blood in stool, weight loss or family history) should prompt for further investigations.[1]

ROAMS IV CRITERIA:

Recurrent abdominal pain on average, at least 1 day per week in the last 3 months, associated with 2 or more of the following 3 symptoms to be fulfilled for the last 3 months, with symptoms onset at least 6 months prior to diagnosis. [The term discomfort included in the Roams III criteria is now eliminated from the new Roams IV criteria]

New ROAMS Criteria include complaint:

- Related to defecation
- Onset associated with a change in frequency of stool.
- Onset associated with a change in form (appearance) of stool.[2]

IBS –subtypes:

IBS is further divided into four subtypes based on predominant pattern of defecation:

1.IBS-C (constipation:>25% hard/lumpy, <25% loose/watery)

2.IBS-D (diarrhoea:>25% loose/watery, <25% hard/lumpy)

3.IBS-M (mixed:>25% loose/watery, >25% hard/lumpy)

4.IBS-U (unclassified:<25% loose/watery, <25% hard/lumpy).

Risk Factors-

GI infection is the strongest risk factor for IBS. The risk is even greater in those who have pre-existing GI conditions such as GERD or dyspepsia, a history of diarrhoea, illness, younger age, female gender, chronic stressful life events, or psychological comorbidities. Other risk factors for developing IBS include an affluent childhood environment, previous antibiotic use, food intolerance, extra-intestinal somatic symptoms, and poor QoL. IBS aggregates in families, and perinatal factors such as young maternal age, caesarean section, and low birth weight are also independently associated with IBS.[3]

Alarming Features seen:

History of:

- Age >50 years
- Unintentional weight loss
- Nocturnal symptoms
- Recent change in bowel habit
- Palpable abdominal mass or lymphadenopathy
- Family history of colon cancer or inflammatory bowel disease
- Anaemia
- Evidence of overt gastrointestinal bleeding (i.e. melaena or fresh blood in stools (haematochezia).[2]

On Physical Examination:

- Fever
- Abdominal mass
- Faecal occult or overt blood on rectal examination.
- Evidence of anaemia.
- Signs of bowel obstruction.
- Signs of thyroid dysfunction.
- Signs of malabsorption.
- Active arthritis.
- Dermatitis.[4]

Pathophysiology:

The pathophysiology of IBS is broad and includes abnormalities involving gastrointestinal dysmotility, visceral hypersensitivity, intestinal mucosal activation, increased intestinal permeability, brain-gut interaction, and psychosocial distress, one of these can usually be demonstrated in the majority of IBS patients. Recent studies have also shown altered gut immune activation and intestinal and colonic microbiome are associated with IBS. Environmental contributors to IBS include early life stressors, food intolerance, antibiotics, and enteric infections and the complex of symptoms would be the result of the interaction between psychological, behavioural, psychosocial and environmental factors.[1],[5]

Clinical Features-

IBS affects all age group, mostly symptoms are seen before the age of 45 years. Women are found to be more effected than men and they make 80% of the population with severe IBS. Pain is now considered as the keynote symptom for the diagnosis associated with change in defecation in the form of frequency and form of stool. Current guidelines recommend that the diagnosis of IBS should be positively made, based on characteristic symptoms.

General Symptoms-

Postprandial symptoms are common in IBS. These symptoms are frequent flatulence and abdominal pain, which are more often triggered by foods rich in carbohydrates or fats, as well as coffee, alcohol, and spicy foods. In assessing the patient with IBS, it is important not only to consider the primary presenting symptoms, but also to identify precipitating factors and other associated gastrointestinal and extra gastrointestinal symptoms. Abnormal stool frequency (>3 bowel movements per day or <3 bowel movements per week), excessive straining during defaecation, urgency (having to rush to the toilet), feelings of incomplete evacuation and mucus with bowel movements support an IBS diagnosis.

Abdominal Pain- IBS should not be diagnosed in the absence of abdominal pain. Abdominal pain in IBS is highly variable in intensity and location. It is frequently episodic and crampy. Pain may be mild enough to be ignored, or it may interfere with daily activities. IBS-C patients reporting more overall symptoms (both lower and upper abdominal pain) and particularly bloating. Pain associated with bowel movements is more common in IBS-D patients than IBS-C patients.

Altered Bowel Habits- Alteration in bowel habits is the most consistent clinical feature in IBS. These symptoms often are variable and intermittent, and patients can change from one stool pattern to another. An irregular stool consistency (abnormal stool form) is characteristic. At first, constipation may be episodic, but eventually, it becomes continuous and increasingly intractable to treatment with laxatives. In some patients, diarrhoea may be the predominant symptom. Diarrhoea resulting from IBS usually consists of small volumes of loose stools. Nocturnal diarrhoea does not occur in IBS.

Gas and Flatulence -Patients with IBS frequently complain of abdominal distention and increased belching or flatulence, all of which they attribute to increased gas. Distention can be objectively measured, in contrast to bloating, which is subjective.

Upper Gastrointestinal Symptoms - patients with IBS may also complain of dyspepsia, heartburn, nausea, and vomiting.

Extra Intestinal Symptoms- Headache, backache, joint pains, impaired sleep, chronic fatigue, dizziness, palpitations, and dyspareunia are more common in IBS patients.

Psychological Features-Psychiatric conditions including depression, anxiety, nervousness and somatization often coexist in IBS. Panic attacks are also common.[1],[2],[3],[6]

Differential Diagnosis:

The differential diagnosis of IBS is broad and ultimately depends on whether the patient has predominant diarrhoea or constipation. If a patient has IBS with diarrhoea, the differentials include lactose intolerance, caffeine intake, alcohol intake, gastrointestinal infections (Giardia, Amoeba, HIV), inflammatory bowel disease, medication-induced diarrhoea, celiac disease, malignancies, colorectal cancer, hyperthyroidism, VIPoma, and ischemic colitis. If constipation is the predominant symptoms, then the differentials can include inadequate fibre intake, immobility, Parkinson's disease, multiple sclerosis, spinal injury, diabetes, hypothyroidism, hypercalcemia, medication-induced constipation, malignancies, bowel obstruction, endometriosis, and diverticular disease. If a patient's history indicates one of these diseases, then appropriate lab testing should be pursued.[5]

Dietary Management-

A large proportion of IBS patients report symptoms triggered by food, and thus IBS is not caused by intake of foods it is only non-specific intolerance to food. Dietary advice should be implemented on regular meals, adjustment of fibre intake, adequate fluid intake, assessment of alcohol and caffeine intake, decreasing fat intake and assessing components of spicy meals which may be contributing to symptoms. The dietary restrictions of fermentable carbohydrates popularly termed as low FODMAP diet (fermentable oligosaccharides, disaccharides, monosaccharides and polyols) is now considered as effective management option for many patients.

Psychological Management-

Stress is strongly associated with symptom onset and symptom severity in IBS patients. Most patients have a relapsing and remitting course. Exacerbations often follow stressful family events, occupational dissatisfaction and difficulties with interpersonal relationships. Trauma and abuse should also be considered and carefully explored. Thus, Patient should be managed by cognitive behavioural therapy (CBT) along with dietary and medicinal management.[1],[5]

Homoeopathic Management-

Homoeopathic treatment involves all the symptoms of IBS whether it be bowel symptoms, psychological symptoms, extra-intestinal symptoms in every individual all together as it is the holistic method of treatment. There are many medicines available in the homoeopathic literature which can be selected on the basis of the presenting totality of each case. Some of the important remedies are detailed below:

Abies nigra – patient suffers from pain in stomach just after eating. Feeling of continuous, distressing constriction just above the pit of the stomach, as if everything was knotted up. Total loss of appetite in the morning, but great craving for food in afternoon and night. Patient also has dyspepsia.

Aloe socotrina- patient suffers from bad effect of sedentary life. headache after stool. Abdomen feels full heavy, hot, bloated. Weak feeling, as if diarrhoea would come on. Great accumulation of flatus, pressing downwards, causes distress in the lower bowels. Colic before and during stools. Constipation, with heavy pressure in the lower part of the abdomen.

Antimonium crudum- Eructation tasting the ingesta. Patients has dyspepsia, heartburn, nausea, vomiting. Gastric and intestinal complaints from bread and pastry, acids, sour wine, overeating. Constant belching. Patient suffers from bloating after eating. Diarrhoea alternates with constipation, especially in old people. Slimy flatulent stools. Stool is composed entirely of mucus.

Argentum nitricum- Belching accompanies most gastric ailments. Nausea, retching, vomiting of glairy mucus. Painful swelling in the pit of the stomach. Painful spot over stomach that radiates to all parts of the abdomen. Gnawing ulcerating pain. Stool watery, noisy, flatulent; green, like chopped spinach, with shreddy

mucus and enormous distension of abdomen; very offensive. Diarrhoea immediately after eating or drinking. Colic, with flatulent distension.

Arsenic album- Nausea, retching, vomiting after eating or drinking. Burning pain, long lasting eructation. Vomiting of blood, bile, green mucus, or brown black mixed with blood. Dyspepsia from vinegar, acids, ice cream, ice water, tobacco. Terrible fear and dyspnoea, with gastralgia. Gnawing, burning pain like coals of fire. Abdomen swollen and painful. Stool small, offensive, dark, with marked prostration. Worse at night and after eating and drinking. From alcohol abuse and spoiled meat.

Cinchona officinalis- Vomiting of undigested food. Slow digestion. Darting pain crosswise in the hypogastric region. Flatulence; belching of bitter fluid or regurgitation of food gives no relief. Severe flatulent colic. Stool undigested, frothy, yellow; painless after meals, from fruit, milk, beer. Very weakening with much flatulence.

Colocynth- Agonizing and cutting pain in the abdomen causing the patient to bend double and pressing the abdomen. Sensation as if stones were being ground together in abdomen and it would burst. Dysenteric stool renewed each time by the least food or drink. Jelly like stools. Distended abdomen.

Lycopodium-Dyspepsia due to farinaceous and fermentable food, cabbage, beans etc. Sour eructation. Great weakness of digestion. Eating ever so little creates fullness. Bulimia, with much bloating. Eating a little create a feeling of fullness in abdomen. After eating, pressure in the stomach, with bitter taste in mouth. Rolling of flatulence. Incomplete, burning eructation rise only up to the pharynx, where they burn for hours. Pain shooting across the lower abdomen, from right to left.

Magnesium phosphoricum- flatulent colic, forcing the patient to bend double; accompanied with belching of gas, which gives no relief. Bloated full sensation in the abdomen and patient constantly passes flatus. There is hiccough with retching day and night.

Natrum Carb- Very weak digestion, caused by slightest error of diet. Bitter taste. Old dyspeptics, always belching. There is a sudden call for stool. Stool which is yellow, like pulp of orange in discharge. There is diarrhoea from milk.

Nux Vomica-Sour taste and nausea in the morning, after eating. Weight and pain in stomach; which is worse, eating, sometime after. Sour, bitter eructation. Nausea and vomiting, with much retching. Region of stomach is very sensitive to pressure. Difficult belching of gas. Wants to vomit, but cannot. Constipation with frequent ineffectual urging, incomplete and unsatisfactory; feeling as if the part remain unexpelled. Alternate constipation and diarrhoea, after abuse of purgatives. Urge for stool is felt throughout the abdomen. Constant uneasiness is felt in the rectum.

Podophyllum- patient has colicky pain and bilious vomiting. Rumbling and shifting of flatus in ascending colon. Vomiting of hot frothy mucus. Stool is watery with jelly like mucus, painless, profuse. Hot sour belching occurs. In the morning there is painless green, watery, fetid, profuse, gushing diarrhoea. Constipation with clay coloured, hard, dry, difficult stool. Constipation alternating with diarrhoea. Headache alternating with diarrhoea.

Plumbum metallicum-Excessive colic in abdomen, radiating to all parts of the body. Abdomen wall feels drawn by a string to the spine. Flatus is obstructed, with intense colic. Constipation; stools hard, lumpy, black, with urging and spasms in the anus. Obstructed evacuation from impaction of faeces.[7],[8]

Conclusion:

IBS is the most commonly diagnosed GI condition and also the most common reason for referral to gastroenterologist. It can affect up to one in five people at some point in their lives, and has a significant impact on quality of life, thus causing high rate of work absenteeism. It can be managed easily by specific homoeopathic remedies by identifying and treating the behavioural components related to a person. As homoeopathic totality of symptoms includes subjective symptoms, mental symptoms and identification of peculiar, characteristic, uncommon symptoms related to the individual thus creating a clear portrait of disease which help in selection of similar remedy.

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