

Research Article

Efficacy of Homoeopathic Treatment In “Irritable Bowel Syndrome” In Its Various Presentations - A Case Study

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Abstract

Irritable bowel syndrome (IBS) is a functional GI disorder characterized by abdominal pain and altered bowel habits in the absence of specific and unique organic pathology. It is also the most common reason for referral to gastroenterologists³. Approximately 10% to 20% of the general adult population has reported symptoms compatible with IBS. Patients often experience the onset of symptoms as young adults and most patients have their first symptoms before the age of 35. IBS has both physiological and psychological determinants. Altered gastrointestinal motility, visceral hyperalgesia, disturbance of brain-gut interaction, genetic and environmental factors, and psychosocial disturbances are variably involved, depending upon the individual. About 50% of IBS patients referred to hospital meet criteria for a psychiatric diagnosis including anxiety, depression, somatisation and neurosis. Panic attacks are also common. IBS has a major impact on the quality of life as it affects social interactions and professional opportunities in suffering population. Thus, IBS has direct financial cost as well as indirect cost affecting quality of life. Currently there is no agreement on the best form of treatment for IBS. Homoeopathy is holistic, cost effectiveness and free of side effects. In the present study, Homoeopathic medicines were prescribed in 30/200/1M potency after detailed case taking, case analysis and repertorization. The results presented are after six months of follow up. Majority of the patients reported highly significant improvement in all symptomatic assessment parameters (highly significant $P < 0.01$; $P < 0.001$). In a five point Likert scale nearly half of the patients ($n=15$, 50%) reported moderate overall improvement

Keywords: Homoeopathy, Functional disorder, IBS

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Introduction

Irritable bowel syndrome (IBS) is a functional GI disorder characterized by abdominal pain and altered bowel habits in the absence of specific and unique organic pathology^{1,2}. It is also the most common reason for referral to gastroenterologists³. In the West, female patients predominate; in India however most reporting patients are young men, probably because of social inhibition in females. Approximately 10% to 20% of the general adult population has reported symptoms compatible with IBS^{4,5}. However, only 15% of those affected actually seek medical attention^{5,6}. Patients often experience the onset of symptoms as young adults and most patients have their first symptoms before the age of 35. IBS has a major impact on the quality of life as it affects social interactions and professional opportunities in suffering population⁷. Thus, IBS has direct financial cost as well as indirect cost affecting quality of life⁸.

IBS is defined on the basis of Rome III criteria as recurrent abdominal pain or discomfort at least 3 days per month in the last 3 months that started at least 6 months before diagnosis and which cannot be explained by a structural or biochemical abnormality, and is associated with at least two of the following: improvement with defecation, onset associated with a change in frequency of stool, and onset associated with a change in form (appearance) of stool. Four bowel patterns may be seen with irritable bowel syndrome. These patterns include IBS-D (diarrhoea predominant), IBS-C (constipation predominant), IBS-M (mixed diarrhoea and constipation), and IBS-A / IBS-U (alternating diarrhoea and constipation/ Un-sub typed). Within 1 year, 75% of patients change subtypes, and 29% switch between constipation-predominant IBS to diarrhoea-predominant IBS. Other symptoms that support the diagnosis include abnormal stool frequency (≤ 3 bowel movements per week or >3 bowel movements per day), abnormal stool form (lumpy/hard or loose/watery), straining for stools, urgency for stools, or feeling of incomplete bowel movement, passing mucus, and bloating. Abdominal pain or discomfort is a prerequisite clinical feature of IBS. This pain or discomfort improves after passing stool and / or has onset with a change in frequency or form of stool. Pain frequently is diffuse without radiation. Common sites of pain include the lower abdomen, specifically the left lower quadrant. Pain may be mild enough to be ignored or it may interfere with daily activities. Despite pain the appetite of the patient is often normal, malnutrition is rare and pain is mostly limited to waking hours, thus patients are not sleep deprived². Altered bowel habit is the most consistent clinical feature in IBS. The most common pattern is constipation alternating with diarrhoea². IBS patient may complain of constipation with symptoms of hard stools of narrow caliber, painful or infrequent and does not respond to laxatives. Initially episodic, constipation may eventually become continuous. Most patients also complain of incomplete evacuation, thus leading to repeated attempts at defecation in a short span of time.

IBS-C patients may have week or months of constipation interrupted with brief periods of diarrhoea^{1,2}. Diarrhoea usually is small volume, with evacuation preceded by urgency or frequent defecation. Most patients have stool volumes of <200 mL. Urgency after eating food is common, as is alternation between constipation and diarrhoea. Nocturnal diarrhoea does not occur in IBS. Diarrhoea may be aggravated by emotional distress or eating. Stool may be accompanied by passage of mucus. Bleeding is not a feature of IBS unless haemorrhoids are present^{1,2}. Patients with IBS frequently complain of abdominal distension and increased belching or flatulence, all of which they attribute to increased gas. However, the reason often is impaired transit and tolerance of intestinal gas loads⁹.

IBS has both physiological and psychological determinants. Altered gastrointestinal motility, visceral hyperalgesia, disturbance of brain-gut interaction, genetic and environmental factors, and psychosocial disturbances are variably involved, depending upon the individual. About 50% of IBS patients referred to hospital meet criteria for a psychiatric diagnosis including anxiety, depression, somatisation and neurosis. Panic attacks are also common².

Published literature indicates that the conventional treatment for IBS is based on trial and currently there is no agreement on the best form of treatment for IBS. Conventional treatment has drawbacks including side effects and relatively higher cost of treatment. So, there need for an effective treatment regimen for IBS that has no adverse effects. Therefore, Homoeopathy with its holistic treatment, cost effectiveness and no side effects can be explored for the treatment of IBS.

Objectives

To evaluate the efficacy of homoeopathic treatment in "Irritable Bowel Syndrome" in its various presentations

Materials & Methods

30 patients who reported to the OPD of Sri Sai Nath Post Graduate Institute of Homoeopathy with symptoms suggestive of IBS and agreeing to be a part of this clinical study were recruited as per the inclusion criteria and exclusion criteria by random sampling method. Detailed case history along with physical examination was carried out in all the patients to confirm the diagnosis as well as to exclude any other pathology. On selection, the detailed case of each patient is recorded on a structured Performa and evaluated.

Inclusion criteria

1. Patients with symptoms according to criteria lay out by Manning and supplemented by Rome II and Rome III symptom criteria.
2. Absence of investigatory evidence of structural disease.

Exclusion criteria

1. Late age onset of symptoms (>40 years).
2. Other organic diseases causing abdominal pain and diarrhoea.
3. Blood in stools (except from anal lesions e.g., haemorrhoids, fissures)
4. A history of previous abdominal surgery
5. Pregnant and lactating women
6. Patients with serious primary diseases of the heart, liver, kidney, blood system or endocrine system or malignancy
7. Mentally or legally disabled patients

Assessment parameters adopted. The symptom score system is introduced to quantify the degree of abdominal pain, diarrhoea, stool consistency and other concomitant symptoms as shown in Table 1 below:

Treatment protocol

A single suitable homeopathic remedy was prescribed after case taking, individualizing each patient and consulting Material Medica/ Repertory. The remedies were used in 30, 200, 1M potencies depending upon the case. Repetition of dose was done on established classical lines – on the basis of potency, age, physical state of individual etc. Cases are followed up weekly or every fortnight for improvement at least for six months.

Statistical Analysis

The information collected on the basis of above observations was subjected to statistical analysis in terms of mean (X), standard deviation (S.D.) and standard error (S.E.) Paired ‘t’ test was carried out at P > 0.05, P < 0.01 and P < 0.001 levels. The obtained results were interpreted as: - Insignificant P >0.05; Significant P < 0.05; highly significant P < 0.01; P <0.001

Table1: Assessment Criteria

| Symptom | Score | | | |
|-----------------------------|----------|----------------------|----------------------|----------------------|
| | 0 | 1 | 2 | 3 |
| Abdominal Pain | VAS 0 | VAS 1-3 | VAS 4-6 | VAS 7-10 |
| Frequency of abdominal pain | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |
| Abdominal bloating | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |
| Loose stools | None | Soft blobs | Mushy stool | Watery |
| Frequency of Loose stools | 1-2/ day | 3-4/ day | 5-6/ day | ≥7/ day |
| Hard stools | None | Hard ≤ 2 times/ week | Hard 3-5 times/ week | Hard > 5 times/ week |
| Straining | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |
| Incomplete evacuation | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |
| Frequency of constipation | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |
| Mucus in stool | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |
| Urgency of passing stool | None | ≤ 2 times/ week | 3-5 times/ week | > 5 times/ week |

Results

The mean age (\pm SD) of the patients was 29.70 ± 8.66 years and the mean duration of complaints (\pm SD) was 30.67 ± 21.13 months. IBS was found to be more commonly reported complaint by the male patients ($n=24$) in the OPD. The age group of 21-30 years and 31-40 years was especially affected. While minimum age was 19 years, maximum age was 56 years. The duration of complaints vary in patients. While maximum duration is 7 years, minimum is 6 months. The patients had a variety of different occupations including students, office goers and housewives. It was clear that life stressors, anxiety and depression were common to all. The predominant miasm in background was Psorosycotic. Patient characteristics are described in Table 2. Nearly 53% of the patients ($n=16$) reported with diarrhoea predominant IBS, 13% ($n=4$) reported with constipation predominant IBS while 33% ($n=10$) reported with alternate diarrhoea and constipation. Frequent passing of stool ($n=23$, 76.7%) was reported by majority of the patients irrespective of IBS-D, IBS-C or IBS-A. The symptomatic presentation of the reporting patients is presented in Table 3. Majority of patients reported symptomatic relief. The results presented are after six months of follow up. Majority of the patients reported highly significant improvement in all symptomatic assessment parameters (highly significant $P < 0.01$; $P < 0.001$) (Table 4). In a five point Likert scale nearly half of the patients ($n=15$, 50%) reported moderate overall improvement, while 7 (23.3%) reported marked, 6 (20%) reported mild improvement and 2 (6.7%) reported no improvement. Worsening of symptoms was reported by none.

Discussion

Homeopathy is holistic mode of treatment that considers body and mind are dynamically interconnected and that both directly influence each other. Mind and body need to be treated together; not in isolation. Homeopathic prescription is based on the physical and psychological symptoms of the sick person where the psychological symptoms often play a primary role in the selection of medicine. Psychological symptoms are thought of as ways in which a person is trying to adapt to biological and psychosocial stresses. Further, Homeopathy is individualization. Homeopathy treats the man in disease and not disease in the man. Homeopathy seeks to find a medicine that matches the totality of the person's physical and psychological symptoms, irrespective of "which came first." Therefore, for the right homeopathic prescription, "the similimum" (similar medicine), it is important to go at the root level in each individual presentation of disease i.e. each patient is treated on basis of individualization. The homeopathic "similimum" initiates a healing process in the patient that beneficial for the overall health of the patient^{10, 11, 12}.

Published literature has indicated the efficacy of Homeopathy in IBS. However, these studies have often had low number of patients/ short-term follow-

up/ high risk bias to draw firm conclusions. Cochrane review of Homeopathic treatment for IBS (2013) identified three RCTs including a total of 213 participants. A meta-analysis of two small studies (129 participants suffering from IBS-C) found a statistically significant difference in global improvement between the homeopathic remedy *asafoetida* and placebo at a short-term follow-up of two weeks. However, the study was not well designed and had short-term follow-up.

One small study found no statistically difference between individualised homeopathy and usual care (defined as high doses of dicyclominehydrochloride, faecal bulking agents and diet sheets advising a high fibre diet). Since this trial had a low number of participants and high risk bias, no conclusions can be drawn it¹³. An IBS clinical trial conducted in the Universities of Leeds and Sheffield recruited 100 patients and compared three groups of patients – those receiving usual care, usual care plus 'supportive listening' and usual care plus homeopathy allowing the influence of the homeopathic consultation and homeopathic medicine to be assessed separately. The initial analysis of this study indicated that, patients receiving homeopathy in addition to conventional care improved more than patients receiving conventional care alone and more than patients receiving 'supportive listening'. This pilot study suggested a clinical benefit from individualised homeopathic treatment¹⁴.

In the present study, Homeopathic medicines were prescribed in 30/200/1M potency after detailed case taking, case analysis and repertorization. The results presented are after six months of follow up. A total of 13 homeopathic remedies were prescribed for IBS after individualising the case. The most prescribed remedies were Sulphur (8), Lycopodium (7) and Arsenic Album (5). *Aloes socotrina*, *Argentum nitricum*, *Chinchona*, *Ignatia*, *Merc solubilis*, *Natrum muriaticum*, *Nux vomica*, *Pulsatilla*, *Silicea* and *Staphysagria* were prescribed to one patient each. The results presented are after six months of follow up. Majority of the patients reported highly significant improvement in all symptomatic assessment parameters (highly significant $P < 0.01$; $P < 0.001$). In a five point Likert scale nearly half of the patients ($n=15$, 50%) reported moderate overall improvement.

Scope And Limitations of The Study

While the results of this study are promising, this is essentially a preliminary study due to small sample size and shows symptomatic improvement. Clinical study with larger sample size and longer follow up duration may be undertaken to further validate the results of this study.

Conclusion

IBS is one of the commonest gastrointestinal diseases that considerably affect the quality of life of suffering individuals. As highlighted by the results of this study Homeopathy has promising results in treating IBS and warrant further studies with more stringent criteria.

Recommendations

In future studies, evaluation for improvement in psychological determinants of IBS including anxiety and/or depression may be done using HADS (Hospital anxiety and depression scale), Beck Depression Inventory-II (BDI-II)- Beck Anxiety Inventory (BAI) etc.

Quality of life assessment may be done using standard quality of life scales including IBS-QOL (Irritable Bowel syndrome-Quality of Life) or WHO Quality of Life-BREF (WHOQOL-BREF) etc

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Table 2: Patient characteristics

| Characteristics | N=30 (%) |
|---|---------------|
| Mean age + SD | 29.70 ± 8.66 |
| Age range (in years) | 17 to 56 |
| Male (%) | 24 (80.0%) |
| Female (%) | 6 (20.0%) |
| Mean duration of complaints (months + SD) | 30.67 ± 21.13 |
| Mean duration of complaints (range in months) | 6 to 84 |
| Family history of similar complaints | 5 (16.7%) |

Table 3: Symptomatic presentation

| Symptom | N=30 (%) |
|------------------------------------|------------|
| Abdominal pain/discomfort | 30 (100%) |
| Abdominal bloating | 24 (80.0%) |
| Loose stools | 16 (53.3%) |
| Hard stools | 4 (13.3%) |
| Alternate hard and loose stools | 10 (33.3%) |
| Frequent stool | 23 (76.7%) |
| Sensation of incomplete evacuation | 17 (56.7%) |
| Straining at stool | 9 (30.0%) |
| Mucus in stools | 14 (46.7%) |
| Urgency of passing stool | 12 (40.0%) |

Table 4: Assessment before treatment and 6 months follow up

| Assessment Criteria | Grading BT Mean ± SD | Grading AT Mean ± SD | T value | P value |
|-----------------------------|-------------------------|-------------------------|---------|----------|
| Abdominal Pain | 2.23 ± 0.43 | 0.67 ± 0.66 | -10.847 | < 0.0001 |
| Frequency of abdominal pain | 2.86 ± 0.34 | 0.87 ± 0.86 | -11.786 | < 0.0001 |
| Abdominal bloating | 2.26 ± 1.20 | 0.93 ± 0.88 | -4.895 | < 0.0001 |
| Loose stools | 1.96 ± 0.89 | 1.00 ± 0.87 | -4.225 | 0.0001 |
| Frequency of Loose stools | 1.60 ± 0.85 | 0.43 ± 0.68 | -5.887 | < 0.0001 |
| Hard stools | 1.00 ± 1.14 | 0.23 ± 0.50 | -3.358 | 0.0014 |
| Frequency of Hard stools | 1.16 ± 1.26 | 0.36 ± 0.56 | -3.178 | 0.0024 |
| Straining | 0.86 ± 1.28 | 0.20 ± 0.41 | -2.720 | 0.0086 |
| Incomplete evacuation | 1.53 ± 1.41 | 0.43 ± 0.73 | -3.802 | 0.0003 |
| Mucus in stools | 1.16 ± 1.31 | 0.33 ± 0.61 | -3.151 | 0.0026 |
| Urgency of passing stool | 1.30 ± 1.15 | 0.26 ± 0.52 | -4.486 | < 0.0001 |

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