



INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

AN OVERVIEW ON IBS AND HOMEOPATHIC MANAGEMENT

¹Dr. Abbagala Yamuna, ²Dr. Katta Akhila,

³Dr. Jakkula Priyanka, ⁴Dr. Koppiseti Alekhya

¹Assistant Professor, Department of Pathology, Microbiology, Parasitology, Hamsa Homeopathy Medical College Hospital And Research Centre, ²Intern, Hamsa Homeopathy Medical College Hospital And Research Centre, ³Intern, Hamsa Homeopathy Medical College Hospital And Research Centre, ⁴Intern, Hamsa Homeopathy Medical College Hospital And Research Centre

ABSTRACT:

Irritable bowel syndrome (IBS) is the most prevalent functional gastrointestinal disorder noted in the general population worldwide. Its chronic nature, signs and symptoms which vary periodically from mild to severe have many negative effects on the quality of life for the sufferer; therefore the appropriate treatment of these patients is highly important. Patients should be informed by their doctors that the nature of the disease is benign, and educated on how to deal with and control symptoms of the disease. This article sets out a review of recent studies on the prevalence of IBS in Iran and appropriate methods for management of patients affected by IBS.

Key words :- IBS, Anxiety, Depression, probiotics

INTRODUCTION:

Irritable bowel syndrome is a functional bowel syndrome characterized by abdominal pain or discomfort and altered bowel habits in the absence of detectable structural abnormalities. IBS is one of the most common conditions encountered in the clinical practice. Most studies show a female predominance. Coexisting conditions, such as non-ulcer dyspepsia, chronic fatigue syndrome, dysmenorrhoea and fibromyalgia, are common. Advances in basic, mechanistic, and clinical investigations have improved our understanding of this disorder and its physiologic and psychosocial determinants. Altered gastrointestinal motility, visceral hyperalgesia, disturbance of brain-gut interaction, abnormal central processing, autonomic and hormonal events, environmental factors, and psychosocial disturbances are variably involved, depending on the individual. This progress may result in improved methods of treatment.

PATHOPHYSIOLOGY :

The cause of IBS is incompletely understood but biopsychosocial factors are thought to play an important role, along with luminal factors, such as diet and the gut microbiota, as discussed below.

BEHAVIOURAL AND PSYCHOSOCIAL FACTORS:

About 50% of patients referred to hospital have a psychiatric illness, such as anxiety, depression, somatization and neurosis. Panic attacks are also common. Acute psychological stress and overt psychiatric disease are known to alter visceral perception and gastrointestinal motility. There is an increased prevalence of abnormal

illness behaviour, with frequent consultations for minor symptoms and reduced coping. These factors contribute to but do not cause IBS.

PHYSIOLOGICAL FACTORS:

There is some evidence that IBS may be a serotonergic (5-HT disorder, as evidenced by relatively excessive release of 5-HT in diarrhoea-predominant IBS (D-IBS) and relative deficiency with constipation-predominant IBS (C-IBS) Accordingly, 5-HT receptor antagonists are effective in D-IBS, while 5-HT, agonists improve bowel function in C-IBS There is some evidence that IBS may represent a state of low-grade gut inflammation or immune activation, not detectable by tests, with raised numbers of mucosal mast cells that sensitise enteric neurons by releasing histamine and tryptase Some patients respond positively to mast cell stabilisers, such as ketotifen, which supports a pathogenic role of mast cells in at least some patients. Immune activation may be associated with altered CNS processing of visceral pu d signals. This is more common in women and in D-IBS, and m be triggered by a prior episode of gastroenteritis with Samui or Campylobacter species.

LUMINAL FACTORS:

Both quantitative and qualitative alterations in Intestinal bacterial microbiota have been reported. Small intestinal bacterial growth (SIBO) may be present in some patients and lead to symptoms. This 'gut dysbiosis' may explain the responded probiotics or the non-absorbable antibiotic rifaximires.

Dietary factors are also important. Non-coeliac gluten sensitivity (negative coeliac serology and normal duodenal biopsies) seems to be present in some IBS patients, while others may be intolerant of chemicals such as salicylates or benzoates, found in certain foods.

LOW GRADE INFLAMMATION:

One of the factors that have an important role in IBS is regulation of the immune system. This can be further alluded to by describing and analyzing its effects on GI infections, IBD and microbial flora.

POST INFECTIOUS IBS:

Between 3 and 35% of patients assessed progress on to develop IBS symptoms three to twelve months after suffering from GI infections.^{32,33} In particular, a rise in mucosal inflammatory cells, especially mast cells, in various parts of the small intestine and colon has been shown. An increase in the release of certain mediators such as nitric oxide, interleukin, histamine and protease leads to the stimulation of the enteric nervous system; such mediators eventually cause impairments in motility, secretion and hyperalgesia of the GI tract.³⁴

CLINICAL FEATURES :-

ABDOMINAL PAIN:

Recurrent abdominal discomfort is the most common presentation of IBS. It is usually crampy or colicky of varying intensity along with periodic exacerbations. Pain is usually located in the lower abdomen, felt in the lower left quadrant and is relieved by defecation.

ABDOMINAL BLOATING:

It worsens throughout the day and cause is unknown but it is not due to intestinal gas and the bowel habit is variable. Most patients alternate between episodes of constipation and diarrhoea but it is important to classify them as predominantly diarrhoea or predominantly constipation.

Those with CONSTIPATION tend to pass infrequent pellety stools, usually with abdominal pain and proctalgia.

Those with DIARRHOEA, have frequent defecation but produce low volume stools rarely have nocturnal symptoms.

Passage of mucus is common and rectal bleeding does not occur, patients do not lose weight and constitutionally well.

OTHER GI SYMPTOMS:

- Gastro-esophageal reflux
- Dysphagia
- Early satiety
- Intermittent dyspepsia
- Nausea and non cardiac chest pain

EXTRA INTESTINAL SYMPTOMS:

- Impaired sexual function
- Dysmenorrhea
- Dyspareunia
- Increase in the frequency and urgency to urinate
- Hypertension, asthma and fibromyalgia

INVESTIGATIONS:

The diagnosis is clinical in nature and can be made using Rome criteria combined with absence of alarm symptoms.

- Full blood count and fecal calprotectin with or without sigmoidoscopy are usually done and are normal in IBS.
- Colonoscopy should be done in older patients to rule out colorectal cancer.
- Endoscopic examination is required to exclude colon cancer and IBS.

ROME 3 CRITERIA FOR DIAGNOSIS OF IBS

Recurrent abdominal pain or discomfort on at least 3 days per month in the last 3 months, associated with two or more of following symptoms:

Improvement with defecation

Onset associated with a change in frequency of stool

Onset associated with a change in form or appearance of stool

Supporting diagnostic features and alarm features in IBS

Presence of symptoms for more than 6 months
Frequent consultation for non gastrointestinal problems
Previous medically unexplained symptoms
Worsening of symptoms by stress
Alarm features
Age > 50 years; male gender Family history of colon cancer
Weight loss Anaemia
Nocturnal symptoms Rectal bleeding

GENERAL MANAGEMENT:

IBS is characterized by a variety of chronic symptoms that include abdominal pain, an alteration in bowel habits and flatulence. The disorder has no definitive treatment but could be controlled by eliminating of some exacerbating factors such as certain drugs, stressor conditions and changes in dietary habits. Hidden drug addiction should be considered as well.

Non-pharmacologic management:

Patients should be given sufficient information regarding their disease condition. For instance, patients should be fully informed of the chronic and benign nature of their condition, that their diagnosis is not likely to be altered, and he or she should have a normal life span. A detailed medical history and physical examination are frequently useful and the examining physician should pay particular attention to their patient's concerns.

The treatment goal in patients suffering with IBS is to reduce their overall symptoms and a subsequent effort should be made to try and eliminate or decrease the patient's primary symptoms which should be addressed on first encounter with the patient. Some recommendations should be put forward to the patients regarding their dietary habits. It should be noted that the intake of foods does not cause IBS; however the contact of food with the GI tissues can convey various effects in individuals suffering from IBS through various immunologic, physiologic and biochemical mechanisms. Therefore recommendations regarding their dietary habits should be based on the following guidelines:

- i) A reduction in inflammation is desired in all parts of the GI tract and 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,
- ii) 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,⁶⁰
- iii) People who have 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.

Psychosocial treatments:

Since anxiety and depression are the most prevalent psychologic conditions among patients affected by IBS, behavioral treatments may be considered in the IBS patients who have associated stress symptoms. Hypnosis, biofeedback and psychotherapy can help to alleviate anxiety levels in these patients.

HOMEOPATHIC MANAGEMENT:

1. *IGNATIA AMARA*: Rumbling in bowels. Weak feeling in upper abdomen. Colicky gripping pains in one or both sides of abdomen. Stools pass with difficulty with painful constriction of anus after stool. Diarrhoea from fright.
2. *Gratiola officinalis*: Dyspepsia with much distension of stomach. Cramps and colic after supper and during night with swelling of abdomen and constipation. constipation with gouty acidity.
3. *Gambogia*: Great irritability of the stomach. Pain and distension in stomach after eating. Rumbling and rolling with dysentery. Diarrhoea with sudden and forcible ejection of bilious stools. Profuse watery diarrhoea in old people.
4. *Mercurius corrosivus*: Bloated abdomen very painful to least touch. Bruised sensation in caecal region and transverse colon painful. Epigastrium very painful. Shreds of mucous membrane and terrible cutting and colicky pains.
5. *Staphisagria*: Colic after anger. Swollen abdomen with much flatus. Diarrhoea after drinking cold water, with tenesmus. Constipation, hard evacuations. Frequent evacuations with scanty evacuation maybe hot or soft.

REFERENCE TAKEN FROM:

1. Davidson principles and practice of medicine 23rd edition
2. Harrison's principles of internal medicine 12th edition
3. Textbook of pathology Harsh mohan
4. Pub med central Irritable bowel syndrome a review article
5. Keynotes and characteristics with comparisons ALLEN.C
6. Pocket manual of homeopathic materia medica BOERICKE W.
7. Synthesis repertory