

Clinical outcomes of Targeted Homeopathic Protocols and Bowel Nosodes in Irritable Bowel Syndrome (IBS): A Retrospective Observational Case Series from Bangladesh

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Abstract

Background: Irritable Bowel Syndrome (IBS) is a prevalent functional gastrointestinal disorder characterized by abdominal pain, altered bowel habits, bloating, and food intolerances, significantly impairing quality of life. Conventional management primarily offers transient symptomatic relief. Targeted homeopathic protocols and bowel nosodes present a potential non-invasive, structured therapeutic option. This retrospective case series evaluates the clinical symptom resolution and dietary tolerance recovery in patients with IBS undergoing a combined homeopathic protocol alongside dietary advice. **Methods:** A retrospective analysis was conducted on 30 patients presenting with IBS-M (Mixed) and IBS-D (Diarrhea-predominant with dysenteric features) diagnosed per Rome IV criteria. Symptoms included frequent evacuation (3–4 times daily), incomplete clearance, mucus-laden stools, dairy/lipid intolerances, and concurrent gastritis. Patients were evaluated over a 3-month period receiving a paired remedy protocol (Mercurius vivus 200C, Chelidonium majus 30C, Mercurius solubilis 6C, Ipecacuanha 30C, Dysentery Compound 30C, and Nux Vomica 30C) alongside a structured 4-week initial trigger food avoidance (Low-FODMAP guidance) followed by gradual reintroduction. **Results:** High rates of clinical symptom resolution were observed across all 30 patients within the 12-week timeframe. Stool frequency normalized to 1–2 evacuations daily, rectal tenesmus resolved, and epigastric discomfort was alleviated. Furthermore, oral tolerance to previously restricted foods (milk, fatty meals, leafy greens) was successfully restored without reported adverse events. **Conclusion:** The observational findings suggest that structured homeopathic protocols paired with bowel nosodes and lifestyle/dietary guidance may serve as a beneficial adjunct management strategy in IBS. Given the retrospective and uncontrolled design, prospective randomized controlled trials (RCTs) are warranted to evaluate causality and long-term efficacy.

Keywords: Irritable Bowel Syndrome, IBS-M, IBS-D, Homeopathy, Banerji Protocol, Bowel Nosode, Low-FODMAP, Observational Study

Introduction

Irritable Bowel Syndrome (IBS) is a major functional gastrointestinal disorder globally, defined by recurrent abdominal pain, bloating, and altered bowel motility in the absence of demonstrable structural abnormalities under

conventional diagnostic criteria (Rome IV). Subtypes include IBS-C, IBS-D, IBS-M, and IBS-U.

In South Asian demographics, particularly Bangladesh, IBS presentations frequently feature rectal tenesmus and mucus-laden evacuations (characteristic of IBS-D), persistent

gastritis, malabsorption, and acute food intolerances (notably dairy products, lipids, and high-roughage foods). The complex pathophysiology involves brain-gut connection disruption, abnormal smooth muscle peristalsis, gut microbiome dysbiosis, chronic stress, and post-infectious reactions [1].

Standard pharmacological therapies (antispasmodics, antidiarrheals, laxatives) provide mostly short-term palliation. Protocol-based homeopathy (such as The Banerji Protocols™) and bowel nosodes (attenuated bowel bacterial preparations introduced by Bach and Paterson) offer an integrative alternative focusing on targeted, organ-specific symptoms [2].

This retrospective study documents clinical observation from 30 patients diagnosed with IBS-M/IBS-D managed with a standardized dual-remedy homeopathic protocol combined with structured dietary modification.

Methodology

Study Design and Setting

A retrospective observational case series was conducted using clinical records from Ansar Homoeo Complex, Narayanganj, Bangladesh, evaluating a continuous 3-month treatment phase.

Inclusion & Exclusion Criteria

- **Inclusion:** Patients aged 8–55 years meeting Rome IV diagnostic criteria for IBS-M or IBS-D with symptom duration > 6 months.
- **Exclusion:** Documented organic bowel pathology (Crohn's disease, Ulcerative Colitis, GI malignancies, intestinal tuberculosis) confirmed via colonoscopy or histology, severe emaciation / alarm features secondary to organic diseases, and patients receiving active immunosuppressant or conventional anti-IBS medication.

Diagnostic Sub-classification

Patients were categorized into pediatric (ages 8-17, evaluated per Pediatric Rome IV criteria) and adult (ages 18-55) cohorts for observational monitoring, with symptoms including altered stool frequency, mucus discharge, incomplete bowel evacuation, and epigastric fullness.

Pharmacological Rationale & Protocol Structure

Remedies were selected based on traditional homeopathic pharmacopoeia literature and targeted protocol principles:

1. *Mercurius vivus* 200C & *Mercurius solubilis* 6C:

Traditionally utilized for rectal tenesmus, excoriation, and mucus-laden evacuations.

2. ***Chelidonium majus* 30C:** Prescribed for hepato-biliary support to address lipid and dairy malabsorption.
3. ***Ipecacuanha* 30C:** Targeted at gastric nausea, hyperperistalsis, and spasmodic colic.
4. **Dysentery Compound 30C (Bowel Nosode):** Administered to support bowel microbiome regulation and chronic dysenteric tendencies.
5. ***Nux Vomica* 30C:** Administered at bedtime for nocturnal gastrointestinal motility regulation, stress relief and intercurrent digestive support.

Administration Schedule:

- **Pair A (Morning & Midday):** *Mercurius vivus* 200C + *Chelidonium majus* 30C (1 hour before meals).
- **Pair B (Evening & Night):** *Mercurius solubilis* 6C + *Ipecacuanha* 30C (1 hour before meals).
- **Bowel Nosode:** Dysentery Compound 30C (Morning & Night, half-hour before meals).
- **Nocturnal:** *Nux Vomica* 30C (Once daily at bedtime).

Integrated Dietary & Lifestyle Management

Patients were provided with a structured Low-FODMAP dietary framework during the initial 4 weeks:

- **Avoidance Phase (Weeks 1–4):** Temporary restriction of raw wheat, heavy fried items, high-fructose fruits (apples), dairy milk, and soft drinks. Recommended foods included white rice, boiled eggs, lean poultry/fish, ripe bananas, carrots, bottle gourd, and clean water.
- **Reintroduction Phase (Weeks 5–12):** Gradual re-exposure to trigger foods to evaluate clinical digestion and oral tolerance.
- **Lifestyle Guidelines:** Recommendation for smaller, frequent meals (4–5 times daily), adequate hydration, 30 minutes of daily walking, and regular sleep patterns.

Ethical Considerations

The retrospective record analysis was conducted in accordance with the Declaration of Helsinki. Institutional review and permission were obtained from the Ethics Board of Ansar Homoeo Complex (Ref: AHC/ERC/2026/02). Informed written consent was obtained from adult patients or legal guardians of minors.

Results

All 30 evaluated patients completed the 3-month observational follow-up.

Patient-Reported Symptom Resolution

Significant improvement was recorded across key

clinical parameters:

- **Stool Frequency:** Average pre-treatment stool frequency (3–4 evacuations/day) reduced to 1–2 well-formed evacuations/day.

- **Tenesmus and Mucus:** Rectal straining and mucus discharge resolved in affected patients by Weeks 4–6.
- **Gastritis & Bloating:** Concomitant epigastric burning and abdominal distension fully subsided.

Clinical Parameter / Symptom	Baseline (Pre-Treatment)	Post-Treatment (3 Months)	Observed Resolution Rate*
Frequent Stool (3–4 times/day)	30 (100%)	0 (0%)	100% Resolved
Incomplete Evacuation Sensation	28 (93.3%)	0 (0%)	100% Resolved
Mucus in Stool / Tenesmus	22 (73.3%)	0 (0%)	100% Resolved
Intolerance to Milk / Dairy	27 (90.0%)	0 (0%)	100% Restored
Intolerance to Oily Foods & Greens	30 (100%)	0 (0%)	100% Restored
Concomitant Gastritis & Bloating	30 (100%)	0 (0%)	100% Resolved

Table 1: Baseline vs. Post-Treatment Patient-Reported Clinical Outcomes (N=30).

*Note: Outcomes based on subjective patient-reported symptom logs and bi-weekly clinical evaluations over 3 months.

Restoration of Dietary Intolerance

By Weeks 8–10, all patients successfully tolerated previously aggravating foods (milk, fried dishes, high-fiber vegetables) without secondary diarrheal relapse or severe abdominal colic. No adverse drug reactions or aggravation phenomena were reported during treatment.

Discussion

Therapeutic Synergy & Hypothesized Mechanisms

The high rate of symptom relief observed may stem from the synergistic interaction between protocol remedies and dietary control:

- Mercurius species are hypothesized to modulate gut mucosal sensitivity and tenesmic rectal irritability.
- Chelidonium majus is reported in homeopathic literature to support hepato-biliary digestion, facilitating lipid emulsification.
- Dysentery Compound (Bowel Nosodes) targets intestinal dysbiosis, acting on gut microflora regulation as documented by Paterson.
- Nux vomica and Ipecacuanha modulate gut motility, addressing anti-peristaltic spasms and stress-induced hyper-motility along the gut-brain axis.

Integrative Lifestyle Strategy

The inclusion of short-term Low-FODMAP dietary modification likely provided initial mucosal relief, allowing targeted homeopathic protocols to exert organopathic effects without continuous dietary provocation.

Study Limitations

Several methodological limitations must be acknowledged:

- **Study Design:** The retrospective, single-arm, uncontrolled design prevents establishing direct causation or ruling out placebo effects.
- **Sample Size:** The small sample cohort (N=30) limits generalization to broader demographics.
- **Objective Markers:** Diagnostic and outcome evaluations relied on clinical symptom reports rather than invasive tissue biopsy, endoscopy, or gut microbiome profiling.
- **Follow-up Duration:** A 3-month evaluation period cannot confirm long-term relapse prevention.

Conclusion

This retrospective case series demonstrates encouraging clinical outcomes using targeted homeopathic protocols paired with bowel nosodes and lifestyle modifications in IBS management [3]. Patients exhibited marked symptom resolution and dietary tolerance recovery. Future prospective, randomized, double-blind controlled trials with larger cohorts and objective laboratory markers are recommended to rigorously validate these preliminary findings.

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