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Some new facts on irritable bowel syndrome - Part II

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ABSTRACT
Irritable Bowel Syndrome took nearly 70-100 years to understand with the first disclosure of discovery due probably to Portal Infection in July 2013 by the present author. Here we shall discuss all those facts which were never thought of earlier by millions and millions of medical personnel who presented their findings in the internet. Here we present our own findings forthwith.

Keywords: Irritable bowel syndrome, Tinidazole, Metronidazole.

INTRODUCTION
The disease Irritable Bowel Syndrome whose real cause was never understood for over 70 years or more is most perplexing and various theories have evolved out of ignorance that are most unfortunate when after a long time of observation and follow up of nearly 60-75 cases that the cecum was periodically inflamed and tender on palpation and auscultation. At that time period the stool examination in the low power microscope had exceptionally a high count of bacteria never seen in normal persons or a patient when he was free from any attack of severe colitis. This was revealed to the author in the first week of August 2013 and through some 60 and odd Emails, a message was dispatched to many places that a 'Gate' opens up periodically in every patient of IBS. The internet is full of old theories built on total ignorance which everybody should go through. Even now they are resisting to give up their old theories like. "Brain-Gut axis", "Functioal Gastro-intestinal disorder", abnormal "Psychopathology" etc. A state of total ignorance had brought in various probable into the field and created chaos and confusion of an enormous magnitude that pervades today.

Prof.Ian Aird published his book, A Companion in Surgical Studies in 1950 which we read as the most wonderful and exquisite text book of the century. He wrote a small chapter on, "Simple Ulcer of the Caecum" when Portal Infection had never been under-stood or disused earlier in text books. Long long after 1950 we read about Ischemia of colon which at first we could not understand or diagnose. Today the time is not ripe for people to understand what Portal Infection in IBS or in Ulcerative Colitis is. It takes some time to study and learn. We have to wait. Several years must past off before the awakening of the truth.

Ulcer cecum; "Gate Theory"; Right Hemi colectomy; Bacterial count in the low power of microscope; Infection of the portal ducts and portal vein; attacks of acute IBS periodically; infection of bile and pancreatic juice; liver function and liver damage. 'Ejection phenomena' when sudden bowel movement and diarrhea occurred just after a normal meal; spasm of a small segment in the colon just distal to the ulcer was never explained and accounted for

later to be due to ischemia. E.R.C.P. now means Endoscopic Retrograde Cholangio Pancreatography performed through the mouth of Ampulla of Vater in the second part of duodenum. Here we only recommend collecting 2 mL bile from the mouth of the duct for bacterial count in low power in comparison with the low power stool bacterial count, as diagnostic of Portal Infection. For each IBS patient this is the final verdict.

MATERIALS AND METHODS

In this experiment with Tinidazole-500 first and then M-400 after 12 hourly intervals continue M-400 for next 48 hours. Total 3 days =T-500 + M-400, five tablets. On 4th day start one tab T -500 and 12 hours later M-400 as before. This controls diarrhea and infection very well.

The first tablet of T-500 was given four days age when there was marked tenderness of Cecum and ascending colon lower part. All went well for 10 days and previous pain cecum and lower half ascending colon were controlled in a better way more rationally than before. Follow this rule henceforth: - T-500 +M-400 x 5 =3 days full= 72 hours in all. Then repeat in that order as outlined above.

Clinical examination in all those three cases showed a small tender mass in the base of cecum that was fixed partly to the tender Iliacus muscle underneath. We clearly understood that the cecum was just slightly thick to be ballooned with gas and liquid as also the lower half of the ascending colon. Periodic auscultation more than six to twelve times a day confirmed our doubts as they were clearly palpable on light pressure over the skin of the abdomen. It was all six to eight inches or a little less long. On some occasions we questioned the three persons whether they experienced colicky pains or not. Sometimes they were painless and sometimes with mild colic mostly 3 to 4 hours after a meal. Sometimes they were painless even with mild palpable spasm or thichness whatever you say so. We examined each of these three persons over 1200 to 2000 times for a period of 45 to 60 days before deciding on right hemicolectomy. No painful colic near caecal ulcer means to us no operation. All our three operated cases had more than a dozen colic pains before we deciding on operation. The author was fully convinced that removal was a must and a cognizable priority as the right next step. I engaged myself to re-examine each one of them, for over two months in each case in the year 1971-72 and then at the end of 1072, stopped further for introspection and review of the past, frequently inspecting the preserved segments there after again and again for more logical facts and evidences out of the three resected specimens. Let us proceed to describe all that.

On opening the abdomen, the first patient had no such ballooning of the ascending colon that had tricked me earlier. It was slightly pale and thickened for about 3 to 4 inches just above the cecum, which we thought as Ischemic nearly 30 years later after the operative removal. Here also there was a second healed ulcer, in only one patient, just in the middle of ascending colon, which we thought as amoebic in origin that had completely healed later before we operated on this patient. When we opened up the right Para-colic gutter there was a little oedematous clear fluid two inches above the first ulcer, due to some old inflammation. It took us just 20 -25 minutes to complete the resection and start emptying out all the faecal matter in jejunum and then illium by gentle pressure with both palms, at least four times patiently before the start of Ileo-colic anastomosis, end to end. Subsequently other two cases were operated at intervals of 2-5 months in the similar fashion, Without any special or new finding other than those of the first case. These two had no second healed ulcer but the lower ascending colon was definitely pale and a little thicker and stiff. This is in brief the story of the three hemi-colectomies of the past. Rightly or wrongly I have now branded all of those as Ischemic segment of a small part only just distal to the mecum, a long time later after 1973.

FLATUS, ITS ROLE IN HEALTH AND DISEASE

Albert Tangerman is a Dutch gastroenterologist at the University Hospital. Why would anyone spend time studying rectal flatus? After all, hell would have to freeze over before this research would win the Nobel Prize in Medicine. But it is rather refreshing, if you will pardon the pun, to learn that a researcher is investigating this malodorous human problem. So none of us should turn up our nose at this unique study. or get careless at a Christmas party. Dr. Albert Tangerman is a Dutch gastroenterologist at the University Hospital Nijmegen. Dr. Tangerman persuaded six adults to collect their flatus. I must admit I would have relished being a fly on the wall

watching this experiment. The subjects were asked to followtheir regular diets. Then as they felt the need to pass flatus their task began. But I doubt that any of them said to friends, "Pardon me while I go and collect my flatus!" How did they proceed? Dr. Tangerman provided each person with a 60 cc syringe. They were advised to press this tightly against the anus during the passage of gas. The syringe was then sealed securely for later examination by gas chromatology. So what makes the odour? Tangerman detected four volatile sulphur compounds in the flatus emissions : hydrogen sulfide (H2S), methanethiol (MT), dimethylsulfide (DMS) and dimethyldisulfide (DMDS). It's been a popular assumption that H2S was the offensive ingredient of flatus. But this was found in only 75 per cent of emissions and DMDS in 25 percent, while MT and DMS were present in all emissions. Tangerman concluded that MT and DMS were responsible for the odor. Their threshold odor concentrations were well above the other gases. But why does rectal flatus have such a penetrating odor? Tangerman says, "of all compounds known in the world, these smell most at the lowest concentrations." Tangerman discovered another sulphur compound (propanethiol) after one subject consumed Greek food. Propanethiol has an extremely pungent and repulsive odour and may be due to the onions in the Greek food.

This research is hardly suitable for dinner table conversation. But just in case Trivial Pursuit enthusiasts are looking for interesting facts here are some additional particulars. Flatus can reach mind-boggling amounts in patients who cannot metabolize lactose, the sugar present in cow's milk.One man suffering from this condition deserves to be in the Guinness Book of Records. He had 141 rectal emissions in four hours after drinking two quarts of milk! I fervently hope he wasn't attending a dinner party. Here's another Trivial Pursuit fact you might fail. Rectal gas is potentially explosive. One patient was undergoing sigmoidoscopic examination for removal of a polyp in the large bowel. When the base of the polyp was cauterized to control bleeding the collection of gas in the bowel caused an explosion. Never, never forget that some flatus is so powerful that it can be detected by smell in levels as low as one part in a million. A word to the wise! Practice restraint during this holiday season. Your search Dr.Albert Tangerman is a Dutch gastroenterologist at the University Hospital Nijmegen. He must also be a super salesman who could sell refrigerators to Eskimos . What will you do to find out whether you are prone to develop Carcinoma of colon and rectum in old age . No one has any idea what causes this cancer to come up. It just came to a surgeon's mind when some two or three persons asked him about the foul smell. He just prescribed Erythromycin estolate and they were cured. It was a miracle cure of foul smell and a great promise for the future generation nearly a year later when he had treated a few more cases similar to the earlier ones. Erythromycin must never be taken concurrently with any one of the following drugs as there is a risk of sudden death from cardiac causes as reported by MIMS (India) Ltd., October 2008,page 13. See MIMS,503 Mansarovar,90 Nehru Place, New Delhi 110019 , INDIA in their monthly Therapeutic Index. Those drugs are :--

Amytriptyline,
Doxepin, Quinidine,
Chloroquine, Haloperidol,
Quinine, Cisapride,
Imipramine, Solatol,
Spiramycin, Pimozide,
Sparfloxacin, Chlorpromazine,
Thioridazine,

The dose of Erythromycin Estolate prescribed by us was 250mg x 5 times daily or 6 times in heavy persons for 3 days (72 hours). This is a diagnosis for the presence of a faint smell. May be some unknown organisms of different types died in the first treatment of foul flatus or gas a man passed out that contained some derivatives of H2S which are all chemical irritants to the colon. They are generated by a number of bacteria that has never been investigated in detail in the past.

The chemicals according to Tangerman are: hydrogen sulfide, methanethiol,dimethyl sulfide, dimethyl disulfide and propanethiol. All these five should be declared as hostile to life as they may generate cancer after years of irritation in the bowels acquired thru fecal oral route, no one knows when and how. The treated patients earlier were very limited in number for last two years after discovery with Erythromycin alone.

The above text was prepared by the author from non-medical literatures and parts from the Internet including Wikipedia in pieces and fragments first time as a medical article on FLATUS. The author had all the credit, who opined that Foul Gases promote Malignancy of Colon and

The Recum, hither to unknown in the medical world. This was in January first week of 2013 when hundreds of Emails were dispatched worldwide Including the one to ms.Fiona Godlee, F.R.C.P.(Lond.), Editor in Chief, British Medical Journal. She was entrusted to give the matter a due importance and thus a new chapter was added in the History of Medicine.

But eventually that faint residual smell died out in a couple of days. But how do you diagnose the nature and formula of those gases? The correct methods is gas chromatography that needs a big laboratory and not in any personal clinic. It took some more months to decide upon some alternate method to move forward in some other direction on this research material and the problem associated with it. We have asked some other persons to do those tests that may take some time and efforts. In an improved version we asked the person for this test to lie down on his bed and cover himself up from head to foot with a thin polythene sheet and capture his own gas and smell it first himself. Those who pass only methane plus carbon dioxide have very faint smell not easily recognised for any objection to another nearby person and also to the patient himself. All understand very well what a rotten egg smells like. The rest conclusion is now clear and we proceed ahead to treat each case for a few days or so.

There has been one or two recurrences of infection after more than eight months, Most likely this time by faecal-oral route, neither recurrence nor due to the presence of some

resistant strains. A man also passes small amounts of hydrogen,carbon dioxide, nitrogen. In this second treatment we used the same drug. These organisms and their variants should be investigated in detail by a micro-biologist after culture and typing in each. It seems some of my patients must have been having one or more of the foul organisms for years and years after their birth in childhood. These organisms might be switching on the cancer disease at the late age by gross irritation in some like all other cancers of various organs and parts of our body. There is a 'switching on' of the mode by these irritants. Some people react violently while others react less. After the completion of each treatment repeated colonisation of bacillus lactis and other favourable organisms had been regularly introduced through the medium of yogurt and medicinal packets now available in the market. We have made it a point to investigate all patients above the age of 20 that come across in practice It has now become a duty for every citizen to carry out his own test and approach a medical person and treat to cure himself with a suitable advice with the drug Erythromycin. We have found out many facts about the smell of flatus. So what makes the odor? Tangerman detected four volatile sulphur compounds in the flatus emissions : hydrogen sulfide (H2S); {methane-thiol (MT) or/ also known as methyl- mercaptan (MM)}; dimethyl sulfide (DMS) and dimethyl disulfide (DMDS). The fifth one later turned out to be Propane-thiol. A sixth one is dimethyl trisulfide(DMTS) now mentioned by Wikipedia. These six devils are under our observation today and we are searching out for more devils and more revelations about the ways they work and manipulate our lives. It's been a popular assumption that H2S was the most offensive ingredients of flatus. But this was found in only 75 per cent of emissions and DMDS in 25 per cent, while MT and DMS were present in all emissions.

Tangerman concluded that MT and DMS were responsible for the odor. Their threshold odor concentrations were well above the other gases. But why does rectal flatus have such a penetrating odor? Tangerman says, "of all compounds known in the world, these smell most at the lowest concentrations."He never thought they may be the prime suspects of introducing a cancerous growth. Tangerman discovered another sulphur compound (propanethiol) after one subject consumed some Greek food. Propanethiol has an extremely pungent and repulsive odor and may be due to the onions in the Greek food he thought. This opinion is not likely to be true. 2-METHYL-3-(3,4 METHYLENE-DIOXYPHENYL-PROPANOL is the full chemical formula. The aroma of the resulting 2-methyl-3(3,4-methylene-dioxyphenyl)-propanol contained no acid smell and was evaluated favorably later. The volatile material that comes out of a cut onion is a volatile sulphur compound: its full name is propanethiol S-oxide. The reason why your eyes weep is that the propanethiol S-oxide gas reacts with the natural water in your eyes and creates sulphuric acid. Of course this irritates your eyes, so they react by producing masses of tears to wash away the irritant. As stated earlier we have used Erythromycin alone and no other drug for the foul smell. At the present moment there is no necessity to change over to some other drug. Someone should let us know if Furoxone is

used instead. We must eliminate cancer of the colon and other diseases by eliminating foul gas producing organisms with some additional antibiotics. Erythromycin is now the best and may remain so for the future.Non medical definitions of the term include "the uncomfortable condition of having gas in the stomach and bowels. These definitions highlight that many people consider as "bloating", abdominal distension or increased volume of intestinal gas to be synonymous with the term flatulence (although this is technically inaccurate). Colloquially, flatulence may be referred to as "farting", "passing gas."

Gas chromatography is a separation technique in which the constituent components of a sample mixture are subjected to a competitive distribution between two phases; one a moving gas stream and the other a stationary liquid or solid. The separation process is performed by introducing a small liquot of the analysis sample into a gas stream (the carrier gas) flowing through a tube (called the column) containing the stationary phase. Two different separation mechanisms are used. In adsorption chromatography the stationary phase is a powdered adsorbent material such as alumina or silica gel, whereas in partition chromatography the stationary phase is a liquid.

Qualitative Analysis by Gas chromatography

Gas chromatography can be used to identify the chemical composition of sample materials. The basis of the use of the technique for this purpose lies in the fact that, under fixed column temperature and carrier gas flow-rate conditions, the time taken for a substance to pass through a particular column is a fixed and repeatable characteristic. The 'retention time' of a substance is a parameter equivalent to it's boiling point or melting point in that it can be used as evidence of identity. However, it must be remembered that, as with melting and boiling point data, a substance's retention time may not be unique and care must be exercised in assigning an identity based solely on retention time measurements. The combination of a gas chromatograph, to achieve a separation of a samples components, with a mass spectrometer detection system which gives chemical structure information has become a popular and powerful means of overcoming the limitations of sample identification made solely on the basis of retention time. Gas chromatography–mass spectrometry (GC-MS) is a method that combines the features of gas-liquid chromatography and mass spectrometry to identify different substances within a test sample. applications of GC-MS include drug detection.

WHAT DOES A SPASTIC SEGMENT INDICATE ?

A physician explains it as "INTENSE VAGAL ACTIVITY" and slower heart-rate but it is actually the beginning of an Ischaemic Segment. Mostly this segment is confined to the right side, proximal half of colon. Powerful drugs like Buscopan or Antrenyl can give a temporary relief, if at all. Watch carefully for 3 years before deciding on resection of a small segment.

Minor affections of IBS

1. Fungal infection in male nipples. Paint with Povidone Iodine for just 12 hours. Never use Tincture of Iodine which is extremely painful.
2. Hair follicle inflammation of Anal Canal with diarrhea must be cleaned with soap water and dried sleeping sidewise on bed. Dried with a clean cloth as swab. Apply a drop of of Cortisone Cream and not oily Ointment for cure in 12 hours.

CONCLUSION

This abnormal state occurs periodically at the end of the digestion when the patient is suffering from fulminant portal bacteremia with infected bile and the entire gut filled with various amines and chemicals generated by a host of foreign organisms that have now multiplied inside the gut and also in the portal vein, bile and liver. Metronidazole 400 or Tinidazole-500 orally will successfully prevent such a mental state if food intake is restricted to ones capacity and overeating prevented with a non-residual nutritious diet.

Foods that are quickly digested and never stagnate for a long time in the gut will successfully prevent such attacks and portal infection. Such a condition will never occur when portal bacteremia is absent during all those intervals when the disease is in the interval of a quiet state with normal digestion. Smaller amounts of non-residual foods will never generate such a psychic state when carefully spaced to prevent stagnation in the gut. This is a very

important fact. In the end I would like to state that stagnation of infected food generates various chemicals and amines that are absorbed into the blood through the portal vein into the general circulation while the diseased liver is unable to detoxicate these chemicals, as advised earlier.

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