Stresclin GI medical information:

Functional GI disorders are among society’s most common conditions. At any one time, approximately 2 out of 5 persons are affected by a functional GI disorder. Furthermore, as the disorders often overlap with each other, many are affected by more than one functional GI disorder simultaneously. Abdominal pain, constipation, dyspepsia, and IBS (Irritable Bowel Syndrome) are in the top six diagnostic categories for gastrointestinal disorders.

IBS is one of the most common “functional” syndromes seen by gastroenterologists and primary care providers with prevalence up to 15% worldwide. It is characterized by chronically recurring lower abdominal pain and discomfort associated with alterations in bowel habits, and in the absence of detectable organic causes for the symptoms, IBS remains defined by symptom criteria.1,2

The fact that IBS like most functional pain disorders share stress-sensitivity of symptoms, show a high degree of comorbidity with psychological symptoms (primarily anxiety and somatization) and psychiatric disorders (anxiety disorder, depression), and respond to CNS directed therapies (both psychological and pharmacological) point towards the important role of the CNS in the pathophysiology of these syndromes.3

Stresclin GI:
This unique mixture of natural active compounds is formulated using the holistic principle that herbs properly combined are greater than the total of each herb separately.

The complex formula containing 9 natural ingredients - Carica papaya, Punica granatum, Musa sapientum, Camellia sinensis, Withania Somnifera, Bacopa monnieri, Curcuma longa, Mentha piperita, Emblica officinalis acts synergically, helping the nervous system and the digestive system restore their balance.

Why Carica papaya?
- Reduces symptomatic dysfunctions of the intestinal tract such as abdominal pain and discomfort, constipation, painful (straining) bowel movements, heartburn
- Papain, Carica’s main active component, reduces gastric acid secretion induced by histamine3
- Protective action against stress-induced ulcer and gastritis

Why Punica granatum?
- Highly active against E.coli, Micrococcus pyogenes, S. aureus, Pseudomonas aeruginosa and S. typhi 4
- High content in vitamin A and E and folic acid, including 40 percent of the recommended daily allowance of Vitamin C.
• A very powerful antioxidant with a potency two to three times higher than green tea or red wine

**Why Camellia sinensis?**

• Extremely potent free radical scavengers due to the hydroxyl groups in green tea chemical structure. The hydroxyl groups form complexes with free radicals and neutralize them, preventing the progression of the disease process

• Green tea polyphenols, particularly EGCG, may be effective in preventing cancer of the prostate, breast, esophagus, stomach, pancreas, and colon

**Why Bacopa monnieri and Withania Somnifera?**

• Contributes to increased adaptation to stress and helps to induce calm and relaxation.

• Reduces general fatigue, physical and mental exhaustion.

**Why Mentha piperita?**

• Peppermint relaxes gastrointestinal smooth muscle by reducing calcium influx in both large intestine and jejunum.

• Reduces IBS symptoms - significant improvement in abdominal pain, distention, stool frequency and consistency, and flatulence

**Mechanism of action – Mentha piperita**

Mentha piperita extract through its essential oils inhibits enterocyte glucose uptake via a direct action at the brush border membrane. Inhibition of secretion by peppermint is consistent with a reduced availability of calcium, acting locally to cause smooth muscle relaxation.

**Why Curcuma longa?**

• Constituents of *Curcuma longa* exert several protective effects on the gastrointestinal tract. Sodium curcuminate inhibited intestinal spasm and p-tolymethylcarbinol, a turmeric component, increased gastrin, secretin, bicarbonate, and pancreatic enzyme secretion.

• Turmeric has also been shown to inhibit ulcer formation caused by stress, alcohol, indomethacin, pyloric ligation, and reserpine, significantly increasing gastric wall mucus

• Powerful choleric effects by increasing biliary excretion of bile salts, cholesterol, and bilirubin, as well as increasing bile solubility, therefore preventing cholelithiasis.

Curcumin’s anti-inflammatory properties and therapeutic benefit have been demonstrated for a variety of gastrointestinal conditions, including dyspepsia, *Helicobacter pylori* infection, peptic ulcer, irritable bowel syndrome, Crohn’s disease, and ulcerative colitis.

**Dyspepsia and Gastric Ulcer – Clinical evidence supporting Curcumin’s health benefits**

In a phase II clinical trial involving 45 subjects (24 males, 21 females, ages 16-60 years), 25 with endoscopically diagnosed peptic ulcers were given 600 mg curcumin five times daily 30-60 minutes before meals, at 4:00 pm, and at bedtime for 12 weeks. Ulcers were absent in 12 patients (48%) after four weeks, in 18 patients after eight weeks, and in 19 patients (76%) after 12 weeks. The remaining 20 patients, also given curcumin, had no detectable ulcerations at the
start of the study, but were symptomatic – erosions, gastritis, and dyspepsia. Within 1-2 weeks abdominal pain and other symptoms had decreased significantly.11

Irritable Bowel Syndrome – Clinical Evidence supporting Curcumin’s health benefits

In patients with irritable bowel syndrome (IBS) the most common symptoms are abdominal pain, bloating, altered bowel habits, and increased stool frequency.12 It is thought that low-grade inflammation of the intestinal mucosa is responsible for some symptomology.13 In an eight-week pilot study of IBS patients, either 72 mg or 144 mg of a standardized turmeric extract was administered to a group of 102 or 105 subjects, respectively. After four weeks, those in the 72-mg group experienced a 53-percent reduction in IBS prevalence, while the 144-mg group experienced a 60-percent decrease. In post-study analysis, abdominal pain and discomfort scores were reduced by 22 percent in the 72-mg group and 25 percent in the 144-mg group.14, 15, 16

Inflammatory Bowel Disease - Clinical Evidence supporting Curcumin’s health benefits

Crohn’s disease (CD) and ulcerative colitis (UC) are the two primary forms of inflammatory bowel disease (IBD). The primary difference between the two is nature and location of inflammatory changes in the gastrointestinal tract. CD can affect any part of the gastrointestinal tract and affects the entire bowel wall. In contrast, UC is restricted to the colon and the rectum and disease is confined to the intestinal epithelium. Although very different in scope, both diseases may present with abdominal pain, vomiting, diarrhea, bloody stools, weight loss, and secondary sequelae such as arthritis, pyoderma gangrenosum, and primary sclerosing cholangitis.17

A pilot study examining the effect of curcumin therapy in 10 patients with IBD (five with CD and five with UC, ages 28-54) who had previously received standard UC or CD therapy. Five patients with proctitis (UC of the rectal area) received 550 mg curcumin twice daily for one month and then were given the same dose three times daily for an additional month. Hematological and biochemical blood analysis, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP) (the latter two inflammatory indicators), sigmoidoscopy, and biopsy were all performed at baseline and at the study end. Symptoms were assessed by questionnaire and daily symptom diary. The other five patients, with Crohn’s disease, received 360 mg three times daily for one month and then four times daily for a second month. Crohn’s Disease Activity Index (CDAI), CRP, ESR, hematological blood analysis, and kidney function was assessed in all patients at baseline and end of study. In the proctitis group all five patients improved by study’s end as indicated by a global score, two eliminated pre-study medications, two decreased their medications, and all five subjects demonstrated normal ESR, CRP, and serologic indices of inflammation after two months. In the CD group, CDAI scores decreased by an average of 55 points, and CRP and ESR decreased in four of five patients.18

Another clinical trial was conducted to assess the efficacy of curcumin as a maintenance therapy in 82 patients with quiescent UC. Subjects were randomized to receive 1 g curcumin twice daily plus sulfasalazine or mesalamine (n=43), or placebo plus sulfasalazine or mesalamine (n=39) for six months. Subjects were assessed at baseline, every two months for six months, and again at the end of a six-month follow-up period via the Clinical Activity Index (CAI) and Endoscopic Index (EI). Only two of 43 patients (4.7%) receiving curcumin plus sulfasalazine/mesalamine experienced a relapse during the six-month study, compared to eight of 39 subjects (20.5%) in the placebo plus sulfasalazine/mesalamine group. Subjects in the curcumin group
also demonstrated significant improvement in CAI (p=0.038) and EI scores (p=0.001), indicating a decrease in UC-associated morbidity. Interestingly, at the end of the six-month follow-up period, during which all patients took only sulfasalazine or mesalamine, eight additional patients from the curcumin group relapsed (total of 23.3%) compared to six additional patients in the placebo group (total of 35.9%). The authors concluded that curcumin plus standard therapy was more effective in maintaining remission than placebo plus standard UC treatment.19

Bibliography:


