Abdominal pain is one of the commonest complaints in the medical outpatient departments. The causes of abdominal pain are very broad and include gastritis, non-ulcer dyspepsia, intestinal colic associated with worm infestations, gastroenteritis and irritable bowel syndrome (IBS). Gastritis pain in the epigastrium is associated with nausea and sometimes vomiting. It is caused with drugs like NSAIDs and infection by Helicobacter pylori. The symptoms of non-ulcer dyspepsia are similar to gastritis and also include other symptoms like abdominal distension and fullness after food.

Pain in the abdomen may be associated with loose stools in conditions like acute gastroenteritis, irritable bowel syndrome, carbohydrate intolerance, inflammatory bowel disorders like Crohn’s disease and ulcerative colitis, etc. In IBS, eating commonly triggers symptoms such as bloating, flatulence, nausea and dyspepsia. Pain is present over one area of the colon, associated with a period of constipation alternating with a more normal stool frequency, relieved by passing of stools. Many a time there is a sensation of incomplete evacuation even after defecation. In carbohydrate intolerance, pain in the abdomen (cramps) usually follows ingestion of foods rich in carbohydrates. Pain in the abdomen is associated with borborygmi, bloating, flatus, nausea and diarrhea.

Along with abdominal pain and diarrhea, Crohn’s disease and ulcerative colitis are associated with bloody stools. The latter may be present with life threatening complications like hemorrhage, toxic mega colon and intestinal perforation.

The causes of abdominal pain may be very trivial and require symptomatic treatment, to subside the pain till definitive treatment is started, which may be continued along with the definitive treatment.

**MATERIAL AND METHODS**

Twenty five patients in the age group of 16-60 years complaining of spasmodic abdominal pain of varied etiology, attending the Department of Kayachikitsa, Institute of Medical Sciences, Banaras Hindu University, Varanasi, were recruited for the trial.

Of the patients selected, 5 of them were males and 20 were females. Three of them had acid peptic disorders, 2 with diarrhea, 1 each had cancer gall bladder, amebiasis, irritable bowel syndrome, and the remaining 7 had non-specific pain in the abdomen. The pain was moderate to severe in 21 patients, mild in 4 patients, dull and aching in 11 patients and spasmodic in 14 patients. Eleven patients had intermittent pain and 14 patients had pain for a longer duration. The patients were administered Himcospaz at a dose of 1 capsule followed by another capsule after 1 hour, subsequently followed by 1 capsule 8 hourly for the next 3-5 days. The response to therapy was evaluated 1 hour after the first dose and after completion of treatment period.
RESULTS
In 22 (88%) patients, it was observed that pain subsided within 30 to 40 minutes. Among 3 patients (12%) there was a relief in pain after the second dose. All the patients had relief from pain. On completion of treatment, 11 patients (44%) were completely relieved from pain in the abdomen, but 14 patients (66%) had recurrence of pain. They were recommended continuation of treatment for further 1 week.

The patients recruited in the trial with diagnosis of severe and acute pain with cancer of gall bladder and acute acid peptic symptoms did not show significant relief and were given conventional analgesics with antispasmodic activity.

No evidence of nausea or vomiting was reported by any patient during the treatment period.

DISCUSSION
This small population based clinical study revealed that Himcospaz was effective in relieving mild to moderate non-specific abdominal colicky pain.

Himcospaz comprises herbs like *Curcuma zedoaria*, *Zingiber officinale* and *Apeum graveolens*. The volatile oils of *Foeniculum vulgare* exhibit antispasmodic effect in the rat’s uterus preparations. *Zingiber officinale* was proven effective in inhibiting the intestinal, gastric and colonic motility. The spasmolytic activity of *Zingiber officinale* could also be attributed to gingerol, an active constituent that was found to inhibit prostaglandin biosynthesis and serotonergic activity. The combination of these active constituents could be responsible for the synergistic antispasmodic effect. Himcospaz has shown non-specific antispasmodic activity in experimental models.

In view of the safety, easy availability and cost effectivity, Himcospaz was proven useful in routine treatment of patients with spasmodic visceral pain of non-specific nature. Further, the efficacy may be confirmed in long-term trial recruiting larger population of patients.