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The Role of Diet in IBS: Reviewing AGA Clinical Updates

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. And joining me today to share practice updates regarding the role of nutrition in irritable bowel syndrome, or IBS, is Dr. Bill Chey, who is a Professor of Medicine at the University of Michigan and Chief of Gastroenterology. Dr. Chey is also the lead author of the AGA Clinical Practice Update on "The Role of Diet in Irritable Bowel Syndrome," which was published in Gastroenterology in March of 2022.

Dr. Chey, welcome to the program.

Dr. Chey:
Thanks so much, Peter. It's a pleasure to be here.

Dr. Buch:
It's a pleasure to have you. So, Dr. Chey, let's start by discussing the nocebo effect. What can you tell us about that?

Dr. Chey:
Well everybody in the audience has likely heard of the placebo effect, the notion that if people believe something is going to make them better, they're more likely, for whatever that intervention is, to actually make them better. The nocebo effect is actually the opposite. So it's this notion that if somebody believes an intervention is going to be harmful to them or make their symptoms worse, they're more likely for that to happen.

Dr. Buch:
Now along those same lines, can you discuss avoidant and restrictive food intake and why it's important for our patients' understanding of this process?

Dr. Chey:
Yeah. This is an important and complicated question because here's the thing, is that restrictive eating behavior is common in GI patients. Think about it this way. If you are a patient and each time you ate a meal you developed symptoms, wouldn't that make you more hesitant to eat? Wouldn't that make you reflect on the foods that might be exacerbating your symptoms? So some degree of restriction is not necessarily abnormal and could be adaptive or protective for patients with food-related GI symptoms.

Unfortunately, that type of restrictive eating behavior can become pathological. You could imagine that if people over-restrict their diet or become so hypervigilant about the foods they eat, that they become malnourished; they require nutritional supplements including and up to things like feeding tubes or even TPN. That could become quite dangerous and pathological, and that defines a condition called ARFID, also known as Avoidant/Restrictive Food Intake Disorder. This is a condition where people over-restrict their diet to the point that they become malnourished or require nutritional supplements or require nutritional support to maintain their nutrition. And unfortunately, this has been a condition that's recently been recognized by DSM-5, so it's actually a codified eating disorder at this point, but it's not necessarily something that gastroenterologists are terribly aware of. And it's something we should be paying attention to because recent survey studies, including work from our own institution, has identified that up to 20 percent of patients being seen in tertiary care gastroenterology clinics actually screen positive for ARFID, so it's much more common than we've previously given it credit for.

Dr. Buch:
With that being said, who are the most suitable candidates for dietary intervention in IBS?

Dr. Chey:
Well the obvious answer to that question is patients who have identified an association between eating food and their GI symptoms, and for IBS, it turns out that the vast majority, more than two-thirds of IBS patients, in some way, shape, or form relate their symptoms to eating a meal. A really important question is the opposite: Who might not be a good candidate for a diet intervention given the fact that the majority of patients associate their symptoms with eating a meal?

In this Clinical Practice Update, we note that if a patient is already on a diet that is restricting culprit foods, for example, high-FODMAP (fermentable oligosaccharides, disaccharides, monosaccharides and polyols) foods, there probably isn't going to be a lot of value in putting them on a restrictive diet that is targeting those same foods they're already restricting. In addition, if a patient comes in and is exhibiting those types of restrictive eating behaviors that we just touched on a moment ago, those are patients you should not put on a restrictive diet intervention. That's really important. You should really think twice about putting those patients on a restrictive diet, and you should probably not do so without the assistance of some of our colleagues in nutrition, like a registered dietitian nutritionist or even a GI psychologist who can help practitioners sort through whether a patient has an eating disorder or not. Also, food insecurity is a big issue. If a patient is struggling to buy their food, putting them on a diet that's going to cost them more money may not be practical or realistic, so just something to keep in mind.

Dr. Buch:
That's very helpful. Who are the best candidates for soluble or insoluble fiber?

Dr. Chey:
Yeah. Fiber is an evolving question. We've tended to focus on this issue of whether it's soluble or insoluble, and that's an important factor based upon the literature that's available. What the literature would say right now is that soluble fiber, so things like psyllium or ispaghula husk, are beneficial for the overall symptoms, and in particular, constipation in patients with IBS. And for that reason the American College of Gastroenterology guideline, or ACG, as well as our AGA Clinical Practice Update suggested the use of soluble fiber in patients with IBS, particularly IBS-C. But the discussion is rapidly evolving and starting to embrace other concepts like viscosity and fermentability, which brings in this whole concept of the low-FODMAP diet. So clinicians should continue to pay attention to the literature as it evolves around the use of fiber in patients with GI conditions, particularly IBS, because it's by no means over.

Dr. Buch:
You made me think of a very important topic that I'm sure you're faced with all the time as well; which fiber do you recommend for patients with mixed IBS?

Dr. Chey:
I would say a couple things. So the first thing is that a lot of patients with mixed IBS will tell you that they have one, two, or three days with either no bowel movement or small, hard, lumpy bowel movements followed by a day or two of "diarrhea." Those patients that endorse that pattern without a bowel movement or only very small movements followed by diarrhea are constipated. They qualify for the diagnosis of IBS-M or IBS mixed by the ROME criteria at the current time and a trial of soluble fiber is a very reasonable way to go.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Bill Chey about updates regarding the role of diet in irritable bowel syndrome. Now, Dr. Chey, if we switch gears a bit, should IBS patients be tested for food allergies?

Dr. Chey:
Yeah, the food allergy discussion continues to evolve as well because for traditional IgE-mediated food allergy, if a patient doesn't have symptoms, like a feeling of swelling or itching in their throat or tongue, development of rashes like urticaria, a history of personal or family history of atopic phenomenon, or comorbid conditions that suggest an autoimmune kind of pathophysiology like asthma, urticaria, etc., food allergies actually are quite rare. Classic food allergy and IgE-mediated food allergy are also rare in patients with IBS symptoms.

On the other hand, there's recent data to suggest that variants of food allergy that we don't completely understand as of right now may be more common and may underlie some of the food-related symptoms reported by patients with IBS.

So, more to come on that, but right now if a patient has those risk factors, I laid out it would be reasonable to refer them to an allergist for formal IgE-related food allergy testing, but that is likely to be uncommon in patients with IBS symptoms, as opposed to these atypical food-related allergic variants that we're just now starting to understand.

Dr. Buch:
I can't wait for that information. And if we turn our attention to the FODMAP diet, what can you tell us about that?

Dr. Chey:
Yeah. So FODMAP , as I think most people are aware, is an acronym that stands for fermentable oligo-, di-, monosaccharides and polyols, and these are basically short-chain carbohydrates and short-chain sugars that your small intestine either has difficulty breaking down and absorbing or just can't break down and absorb, and for that reason they get to the distal small bowel and colon where they are fermented by the resident bacteria producing a whole myriad of different byproducts, perhaps, arguably most important of which are gases which lead to luminal distension and short-chain fatty acids. Which not only creates an osmotic load but also changes the pH of the luminal microenvironment of the colon and the concentration of various short-chain fatty acids, and in that way can influence things like bile acid levels, permeability, immune activation in the GI tract, motility, and visceral sensation, which we know are really important to the pathogenesis of IBS. So the idea here is that by restricting FODMAPs, we reduce fermentation, reduce the production of gases, and short-chain fatty acids, and in that way that could help symptoms in patients with IBS who have underlying abnormalities with motility and visceral hypersensitivity.

It's really important to remember that the FODMAP diet is not only just eliminating FODMAPs from the diet. There's a short period of time where those FODMAPs are eliminated, and if there's a response, you reintroduce foods containing individual FODMAPs, and then use that information to tailor the diet so it's not so restrictive over time.

Dr. Buch:
Those were some very important insights when it comes to treating our patients with irritable bowel syndrome. And I want to thank my guest, Dr. Bill Chey, for an excellent discussion. Dr. Chey, it was great speaking with you today.

Dr. Chey:
Thanks so much, Peter. It was a pleasure.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening and see you next time.