Medical Nutrition Interventions for Common Digestive Disorders – Participant Questions Answered by Presenter, Nancee Jaffe, MS, RDN

1. IBS may be defined as requiring pain, but what about people who have a very high pain threshold and may not acknowledge or recognize it as pain but instead as pressure or just discomfort?

   The definition of IBS changed from discomfort to pain in the last incarnation (2016): The Rome IV criteria (Table 1) differ from the Rome III criteria (Table 2) in several distinct ways. One, the term "discomfort" was removed from the current definition and diagnostic criteria, because some languages do not have a word for discomfort or it has different meanings in different languages. Additionally, based on a study of IBS patients who reported wide variations in their understanding of these terms, it is unclear whether the distinction between pain and discomfort is qualitative or quantitative [10]. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5704116/)

   According to Rome criteria, discomfort is an uncomfortable sensation not described as pain. So technically, they would not fit the definition for IBS. But, I often find using different measuring scales to assess pain can give you a better indicator. Often times if patients call their symptom discomfort, when you ask them it a different way, such as "on a scale of 1-10 have much does this discomfort affect your daily activities", they rate it an 8 or above, which I would call pain.

2. We have some patients who don't become replete when oral B vitamins used. Of course, we also use injections of B12 but do you have a source for injectable forms of other B's? They seem to be hard to locate. Also, when using in vitamin E in those who are deficient due to malabsorption, what form do you use? For example, do you include tocotrienol. These questions are related to the people we see with Ehlers Danlos and associated motility/malabsorption issues- several with low pancreatic elastase

   Injectables are available through the UCLA pharmacy, so unfortunately, I do not know the sources for injectable forms of B's outside of this facility. Sorry to not be more helpful here!

   For the vitamin E question, I hope this will be helpful:

Chimia (Aarau). 2014;68(3):129-34. doi: 10.2533/chimia.2014.129.**Vitamin E and vitamin E acetate absorption from self-assembly systems under pancreas insufficiency conditions.**

Nagy K[1], Lobo B[2], Courtet-Compondu MC[1], Braga-Lagache S[1], Ramos L[2], Puig-Divi V[3], Azpiroz F[4], Malagelada JR[4], Beaumont M[1], Moulin J[1], Acquistapace S[1], Sagalowicz L[1], Kussmann M[5], Santos J[4], Holst B[1], Williamson G[6].

3. What are your thoughts on the GAPS diet vs the Low FODMAP diet?

   From my understanding, the GAPS diet is not substantiated by evidence at this point so I have never used it with IBS patients. Furthermore, it is based on the Specific Carbohydrate Diet which has not shown benefit for IBS patients, whereas the low fodmap has shown great benefit to IBS patients:

   J Transl Int Med. 2017 Jun 30;5(2):120-126. doi: 10.1515/jtim-2017-0004. eCollection 2017 Jun. **Effects of a Low FODMAP Diet and Specific Carbohydrate Diet on Symptoms and Nutritional Adequacy of Patients with Irritable Bowel Syndrome: Preliminary Results of a Single-blinded Randomized Trial.** Vincenzi M[1], Del Ciondolo I[2], Pasquini E[2], Gennai K[2], Paolini B[2].

4. If a patient has a very high CRP and SED rate with occasionally loose stools do you think it would be worth trying a FODMAP diet?

   It seems like further workup is needed – have they been ruled out for inflammatory bowel disease, celiac disease, malignancy, etc. first? Instead of a full low fodmap diet, I might start by looking at the diet for sources of excess fructose, polyols and/or lactose and simply swap out current high foods for alternatives to see if it helps.

5. How long do you recommend patient's follow the elimination phase before starting the rechallenge phase?

   I do 4 weeks, though research shows benefit in as little as 2 weeks or needing as much as 6 weeks for full effect.

6. What about SmartBrief news email that GF and FODMAP did not help much?

   A few words inspired by Kate Scarlata: This article was looking at global IBS symptoms, not specifically pain and bloating, which are the main benefits derived from the low

fodmap diet. Plus, clinically-speaking, we see it works for our patients. I agree that more research in this area with larger numbers would be great, but not easy to achieve.

7. My client states she has a "storm' in her stomach. Physician ordered Omeprazole daily. No relief. Then went to Omeprazole BID. She followed the Fodmap diet and the re-introduced foods. No relief. What should be tried next?

   I would want more specifics about the "storm" --- is she describing pain, discomfort, pressure? Are there noises (popping, hissing, gurgling)? Does passing gas or stool help? How effective are the bowel movements currently? Questions like this might help identify the underlying cause, which could lead to better suggestions for symptom resolution

8. Do you have a advice for Vegetarians?

   I am assuming this is advice for vegetarians who also have functional gut disorders ---- here you go!

   http://blog.katescarlata.com/2014/10/07/quick-tips-low-fodmap-vegetarian/
   http://blog.katescarlata.com/wp-content/uploads/2014/10/Vegan-Menu-Planning-Low-FODMAP.pdf

9. Can you discuss how to maintain glycemic control in the setting of gastroparesis with a low fiber, low fat diet?

   I am not a CDE so am fortunate enough to work with diabetes expert dietitians at UCLA to coordinate care for these patients, but I am always focused on ways to get more proteins and vegetables into the diet – can we give soluble fiber vegetables (such as carrots, green beans, insides of eggplant, asparagus tips) as a puree or soup? Or use these vegetables to bake with, such as zucchini muffins? What about ground animal proteins or protein drinks (either homemade to reduce total carbohydrates or mixed with premade meal replacement shakes to aid with caloric and protein intake?)

10. What about Histamine Intolerance, since there are similar symptoms how can the FODMAP diet help?

    Great question, low histamine diet is almost in direct opposition to the low fodmap diet! Low fodmap allows fermented low lactose dairy (cheeses, goat yogurt, etc) and slow leavened sourdough bread, while the low histamine diet forbids these foods. If a patient

gets worse with the low fodmap diet and exhibits typical histamine symptoms (diarrhea, abdominal pain, rashes, hives, dermographism, low blood pressure, etc) then that could point you in the direction of the low histamine diet.

11. Won't charcoal interfere with nutrient absorption even if taken apart with food?

    There is not good research on this, but data has shown it will bind with alkaloid medications (such as colchicine), vitamin K, receptor antagonist medications (such as beta blockers), and acetaminophen. To be safe I have patients take 4 hours after supplementation or medications.

12. Is use of probiotics beneficial?

    Check out this article to help answer this question:

    Am J Gastroenterol. 2009 Apr;104(4):1033-49; quiz 1050. doi: 10.1038/ajg.2009.25. Epub 2009 Mar 10.**The utility of probiotics in the treatment of irritable bowel syndrome: a systematic review.** Brenner DM[1], Moeller MJ, Chey WD, Schoenfeld PS.

13. This was fantastic. Thank you. Would you recommend the Monash FODMAP certification for health care providers?

    Many thanks! The certification is useful if you have the money and time to spend. I am taking the course right now and it has great information.

14. There is a patient who is a frequent flyer at our hospital. She has gastroparesis and doctors continuously want her to begin supplementary TPN as she only eats very small amounts (a few bites, of pop tarts, cereal, etc.). She is not my patient, so I am not sure why EN has never been recommended. Which type of EN formula do you typically recommend for gastroparesis patients (non-diabetic)?

    I am not a CNSD and am fortunate to have an EN/TPN clinic here at UCLA that determines formulas for these patients. I believe a peptide formula is preferred such as Peptamen or Kate Farms.

15. Which, if any of these supplements are safe during pregnancy (digestive enzymes, activated charcoal, enteric coated peppermint or simethicone)?

    Peppermint unfortunately is not (at least not in the first and second trimester), but digestive enzymes are allowed. Since simethicone is technically an OTC I usually leave it up to the OBGYN to determine if safe. Activated charcoal has not been studied in pregnancy so I personally would not use.

16. What was the low viscous fruits mentioned in the presentation?

    Stone fruits no skin

17. Do you know of any adverse effects from long-term supplementation of enzymes?

    None that I am aware of – since they are not pancreatic enzymes but enzymes the patient is either not making enough of (lactose) or never made in the first place (alpha-galactosidase), it appears to be free of adverse effects from long term use.

18. Have you found the supplement Beano to be effective for your patients with IBS and bloating problems?

    Beano contains polyols (mannitol); I tend to use other forms of alpha-galactosidase.

19. Do probiotics help gastroparesis? If so, can you name a brand?

    The only research is on probiotic use to manage bloating in gastroparesis patients, so no, nothing specific to gastroparesis itself:

    "Probiotic use was higher in those with the most severe bloating. However, the numbers of patients on probiotics in this investigation were small regardless of bloating severity. Thus, the utility of probiotic supplementation in gastroparesis warrants further study." (https://www.nature.com/articles/ajg201181)