"Identifying and Preventing Nutrient Deficiencies in Patients Following Therapeutic Diets for Gut Health"

Webinar Questions Answered by Colleen Webb, MS, RDN

Please note that these are brief answers to complex questions and are not meant as medical advice. Please seek medical advice from your personal healthcare professional for more complete information.

- **I have found that insurance payment is an issue for some of the GI tests you measured. What has been your experience?**

In my experience, most insurance companies will cover basic blood work for nutritional deficiencies, including vitamin D, vitamin B12, folate and an iron panel. When deemed medically necessary, they'll usually cover a celiac panel (to rule out celiac disease) and fecal calprotectin (to assess for intestinal inflammation).

- **Regarding elimination diets for IBD, quinoa is often avoided as it is believed to feed "bad" bacteria while offering low prebiotic benefit. What are your thoughts on this topic?**

The Specific Carbohydrate Diet (SCD), a popular dietary approach for IBD, excludes quinoa because it's a source of complex carbohydrates. This diet is based on the idea that people with IBD poorly digest and absorb complex carbs, so they're available to feed "bad" bacteria. However, there is no evidence to support this theory, and quinoa is allowed on other exclusion diets, including the low FODMAP diet.

- **Do you find Quercetin to be helpful for digestive enzyme supplementation?**

I'm not aware of any of my patients using quercetin as a digestive enzyme.

- **How long would a person need to have a poor calcium consumption for it to show on a DEXA scan?**

Calcium consumption is just one of many factors influencing bone health, so it's difficult to determine how long poor calcium intake would take to negatively affect bone density.

- **How long do you keep patient at each step of the FODMAP diet?**

Elimination Phase: 2-4 weeks (some providers may go up to 6 weeks)
Reintroduction Phase: approximately 6-8 weeks
Maintenance: as needed

- **I know a couple of males who have the opposite effect when consuming dairy -constipation. What do you suspect as the cause and what dietary recommendations would you make?**

Dairy fat, protein and lactose all have the potential to worsen constipation in certain individuals. Plus, dairy might be displacing other foods, especially those higher in fiber. Once you better understand the reasoning (such as lactose intolerance, cow's milk intolerance, or a low-fiber diet), you can recommend an appropriate solution. In many cases, people just need to eat more fiber.

- **What are your thoughts on taking a digestive enzyme before each meal such as Beano? I have IBS and this was a gamechanger for me.**

That's great! The active ingredient in Beano, alpha-galactosidase, breaks down galacto-oligosaccharides (GOS) found in beans and certain vegetables like broccoli and Brussels sprouts. It's safe to use, allowing people to take it as needed to better tolerate these foods.

- **Do you have a good quick response to address questions on leaky gut? Both RDs claiming it's "not a legitimate diagnosis" and patients with no healthcare background?**

Quick answer: It depends on their definition of “leaky gut.” In healthcare, “leaky gut” refers to reduced intestinal barrier function and increased permeability. The intestinal barrier is selectively permeable, allowing necessary substances, like nutrients and electrolytes, into the body. However, with “leaky gut” or hyper permeability, the membrane becomes less selective, allowing potentially harmful substances to pass though the intestinal barrier, mounting an inflammatory response.

Longer answer: Check out Orgain’s previous webinar “Promoting Gut Barrier Function for Better Health: Addressing Leaky Gut Through Diet”

- **What can we do to help get fiber into diet for those prescribed to follow a low fiber diet by GI doc?**

A “low fiber” diet typically refers to a “low roughage” diet. Softer forms of fiber-rich foods generally work well. Examples include well-cooked vegetables, creamy peanut, nut and seed butters, soft fruits without thick skins or seeds, hummus, smoothies, pureed soups, pestos, and porridges.

- **What do you think are the healing factors of the Mediterranean diet?**

I suspect it’s because a traditional Mediterranean-style diet, like other traditional dietary patterns, is rich in essential vitamins, minerals, healthy fats, dietary fiber and polyphenols, and low in ultra-processed foods, added sugar and animal products.

- **Do you just recommend your patients to take a multivitamin to help mitigate diets that may be insufficient in vitamin/minerals? I find trying to tell my patients to eat xyz for Ca, xyz for vitamin Bs is challenging because they are anxious over foods and tolerance. Thoughts?**

When my patients are unable to consume a wide variety of foods from every food group, I do frequently recommend a multivitamin/mineral supplement for added reassurance.

- **I have had IBS/ IBS/C for 57 of my 62 years and been in the field as an MS RDN for 40 years. There is no information noted on fried or fatty foods. Thoughts?**

Fatty meals are well-known triggers for a variety of GI symptoms related to many GI conditions, including IBS and IBD. Besides worsening symptoms, fried foods and excess animal fat are associated with inflammation in IBD. Evidence-based dietary guidelines from the International Organization for IBD recommend that patients with Crohn’s disease and ulcerative colitis limit their intake of saturated fats and trans fats to reduce their risk of flaring.

- **What are your thoughts/experiences with integrating intuitive eating into dietary interventions for your GI patients? Do you see any compatibility between IE and exclusion diets for optimizing health in GI patients?**

Absolutely, patients following exclusion diets can still practice and reap the benefits of intuitive eating. We can help by reminding our patients that any dietary restrictions are temporary and by not labeling foods as “good” or “bad”.

- **Do you have any recommendations for people taking Wegovy and the diets you covered today?**

No specific recommendations as most GI therapeutic diets focus on eating whole and minimally processed foods.

- **What advice do you have for people who travel / go to a lot of social engagements when following elimination diets?**

Most elimination diets are short-term, so it’s best for patients to plan them for when they don't have major social engagements and travel. During these times, consider other tools to help minimize symptoms—such as digestive enzymes, diaphragmatic breathing, and mindful eating. Encourage patients to chew their food well, eat slowly, taste their food, and be mindful of portion sizes. Often, *how* we eat has a bigger impact on how we feel than *what* we eat.

If following elimination diets during these special times is inevitable, suggest patients pack snacks, research menus and local cuisines in advance, and speak with waitstaff and hosts about simple substitutions.

- **Can you talk about fiber and IBD flare ups?’**

Most importantly, we have no evidence that dietary fiber causes flares. In fact, research suggests the opposite is true. Fiber intake is associated with a reduced risk of flares and increased time between flares. That said, there are times when IBD patients need to avoid or limit foods with insoluble fiber (commonly known as roughage). During these times, patients can opt for softer variations of fiber-rich foods, such as well-cooked vegetables, creamy peanut, nut and seed butters, soft fruits without thick skins or seeds, hummus, smoothies, pureed soups, pestos, and porridges.

- **Do you recommend vitamin D and K together?**

If dietary intake of vitamin K2 appears low, then I’ll recommend supplementation, usually in combination with vitamin D3.

- **Any considerations for patients who find symptoms are worsened by fiber? Do you still aim for a high fiber diet eventually?**

Dietary fiber can pose challenges for GI patients for two key reasons: 1) Roughage, and 2) FODMAPs. If roughage seems to be the cause, patients can adopt a low roughage version of a high-fiber diet. If specific FODMAPs are problematic, they can eat a variety of tolerated foods, monitor portion sizes, modify FODMAP load, and/or experiment with particular digestive enzymes.

- **Do you ever recommend allergy testing to rule out concurrent food issues?**

If someone reports symptoms like itching of the mouth or skin, hives, swelling of the throat, difficulty breathing, fainting or other allergy-type reactions to foods, I'll refer them to an allergist. Or, if I expect histamine intolerance, I might refer. However, since I work with adults who are less likely than children to suddenly develop a food allergy, I hesitate to send them for food allergy testing. It's known to be unreliable and can yield false positive results, which may lead to unnecessary dietary restrictions and food fears.

- **Do you recommend pelvic floor physical therapy for patients with constipation or just in certain situations?**

In my experience, patients who most often benefit from an evaluation for pelvic floor dysfunction are those who report very infrequent BMs (less than once a week), incomplete evacuation, bloating after consuming any food or drink (including water) and/or who have poorly responded to laxatives, fiber supplements and/or a high fiber diet. They should speak with their gastroenterologist to discuss their options, including a potential referral to PT.

- **Any experience with the AID-IBD diet?**

Yes. The IBD-AID (developed at UMASS Medical Center) stems from the Specific Carbohydrate Diet (SCD). However, while it continues to eliminate most complex carbs, it encourages natural sources of prebiotics, including barley and oats, as well as some probiotics. Anecdotally, it works well for people with IBD, but research is limited to one small case study.

- **Do you think the use of probiotics can help or worsen certain GI patients?**

Many studies have explored the role of probiotics in managing GI conditions, but the findings are inconclusive. In general, they're likely safe, except in SIBO where we worry about more bacteria building up in the small intestine. And, in some scenarios they may be helpful, such as pouchitis and preventing antibiotic-associated complications. However, probiotics are not created equal and their efficacy likely depends on one's individual microbiota. The US Probiotic Guide can help advise you on what (if any) microbial strains and products may work best your patients.

- **Are tests for food sensitivity helpful to personalize the diet?**

Since food sensitivity tests are unvalidated and lack supporting research, many practitioners don't routinely recommend them. However, I've worked with patients who report feeling better when they follow personalized dietary therapies, guided by knowledgeable dietitians, based on results from certain food sensitivity tests.

- **What programs or resources do you recommend to become more knowledgeable and an expert in GI nutrition?**

There are many wonderful resources available for clinicians to expand their knowledge of GI Nutrition. For dietitians, a great starting point is to join Dietitians in Gluten and GI Disorders (DIGID), a sub-unit of the Dietitians in Medical Nutrition Therapy, a dietetic practice group of the Academy of Nutrition and Dietetics.

Also, two GI dietitians have recently launched the GutEd Guide Book, a free, up-to-date guide featuring evidence-based resources to help providers expand their GI nutrition knowledge.

- **What is the best dietary approach for Collagenous colitis?**

Currently, the best dietary approach for managing collagenous colitis focuses on minimizing symptoms during flare-ups. For many people, this involves a low-sugar, low roughage diet full of whole and minimally processed foods. Others may feel better with a low FODMAP diet. Some patients benefit from a hybrid of these approaches, such as following a low-roughage, low-sugar, gentle low FODMAP diet.

- **You mentioned if patients feel worse after exclusion diet, they may have histamine intolerance or sucrose isomaltase deficiency. Are there specific tests to test for this? And are there any other examples you have at the top of your head?**

Those were just two examples of how exclusion diets can reveal other potential issues. If a patient reports worsening symptoms while following an elimination diet, compare the differences between their usual diet and the elimination diet. These observations can guide further testing.

The best way to assess for a sucrase-isomaltase deficiency is through endoscopic biopsy. Currently, there is no objective test for histamine intolerance.

- **How do people with IBD-diarrhea type get enough fiber for a healthy microbiome?**

Food is complex and can trigger diarrhea and other symptoms in people with IBS-D for various reasons. Sometimes, fiber intake doesn't need to be adjusted because other factors like lactose, sucrose, fat, caffeine, alcohol, and/or spicy foods are the culprits.

If fiber appears to be the issue, it's important to determine whether it's due to roughage or FODMAPs. If roughage is the problem, patients can follow a low-roughage version of a high-fiber diet. If specific FODMAPs are causing issues, they can focus on eating a variety of tolerated foods, monitoring portion sizes, adjusting FODMAP load, and experimenting with specific digestive enzymes.

- **Does a low FODMAP diet or Fodzyme supplements help with constipation?**

A low FODMAP diet has not been shown to be as effective for those with constipation. However, since constipation can lead to a buildup of gas, reducing highly gas-producing foods (like some FODMAPs) can help manage associated symptoms like gas and bloating.

- **Any thoughts on how glyphosate affects gut health?**

We have lots to learn about the impact of glyphosate on human health, including gut health. Some research suggests glyphosate could negatively impact the structure and function of the gut microbiota, potentially leading to detrimental consequences. Also, glyphosate exposure may play a role in non-celiac gluten/wheat sensitivity.

- **Do you think following a low FODMAP diet based on symptoms can be just as effective as doing the full low FODMAP diet? For example, restricting lactose, polyols, fructans if they have loose stools.**

It's possible. Recent research suggests that a simplified version of the low FODMAP diet may be as effective as a strict elimination diet.

- **I have a patient with chronic bulging/burping after he eats gluten-free carbohydrates. He has been diagnosed and treated with SIBO with antibiotics. Would a low FODMOP diet help with chronic burping?**

Many gluten-free foods, such as oats and quinoa, are low FODMAP. So, that observation alone doesn't indicate that a low FODMAP diet will be beneficial. Instead, a short-term low-starch diet might be worth considering.

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