Assessing Bloating and Distention

*with an Eye for
Eating Disorder Risk*

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Disclosures

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None

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None

About The Presenters

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Owner of Gentle GI, a trauma-informed GI practice with expertise in GI/eating disorder overlap and disorders of gut-brain interaction

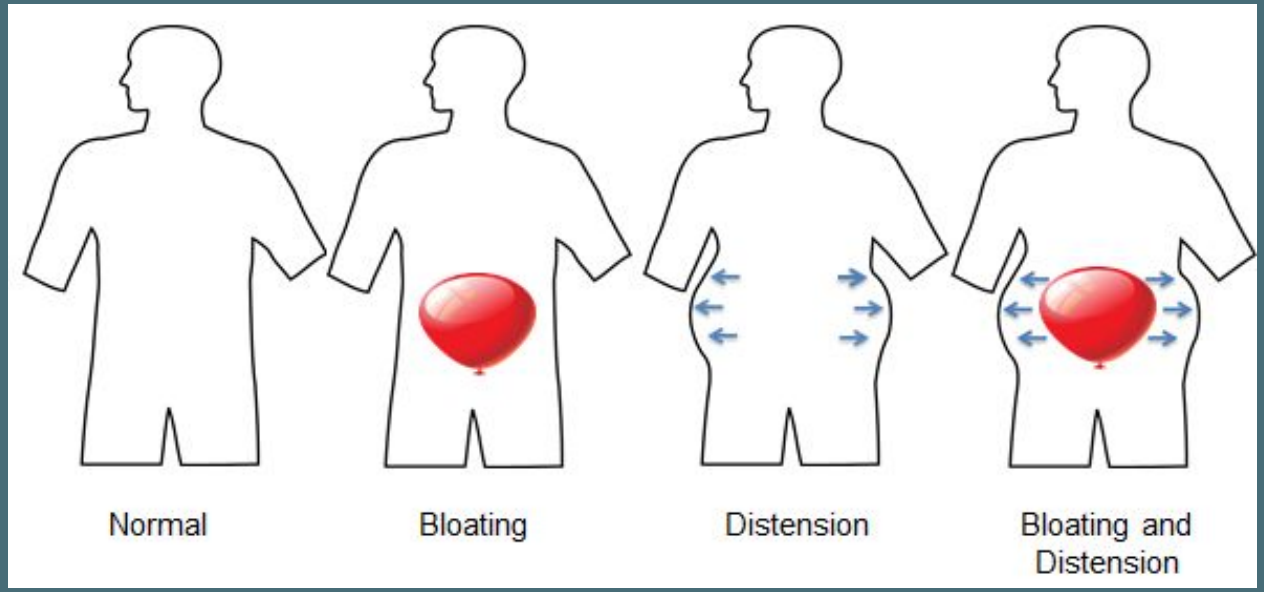
Co-author of *Comprehensive Nutrition Therapy for Co-Occurring Gastrointestinal and Eating Disorders*

Learning Objectives

1. Develop an approach to identify causes of bloating
2. List alarm symptoms that would indicate a more immediate gastroenterology referral
3. Identify two interdisciplinary referrals that can be made for chronic constipation
4. Describe the risk of undertaking elimination diets and alternative therapeutic approaches

Bloating vs Distention

Global prevalence: ~18% (range 11-20%)



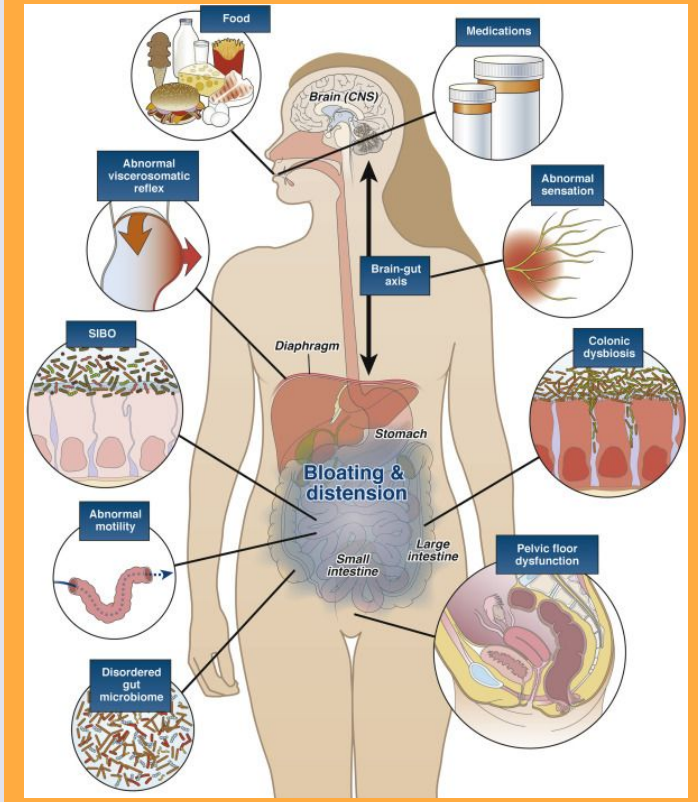
Ballou et al. 2023

Major Causes of Bloating

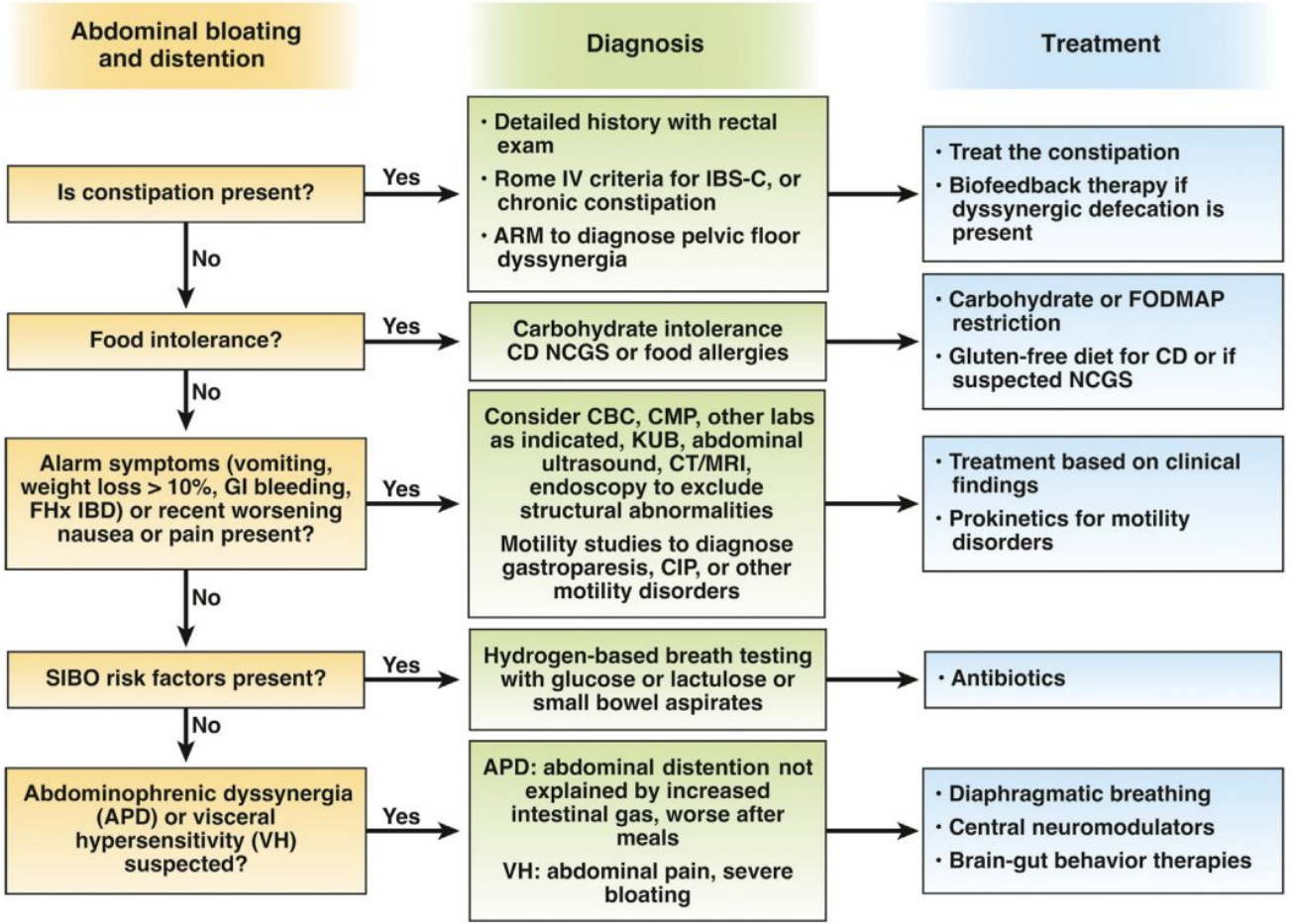
Lacy et al. 2021

Organic/Pathlogic Etiologies
-Small intestinal bacterial overgrowth
-Lactose, fructose and other carbohydrate intolerances
-Celiac disease
-Pancreatic insufficiency
-Prior gastroesophageal surgery (e.g. fundoplication, bariatric surgery)
-Gastric outlet obstruction
-Ascites
-Gastrointestinal or gynecologic malignancy
-Hypothyroidism
-Small intestine diverticulosis
-Chronic intestinal pseudo-obstruction

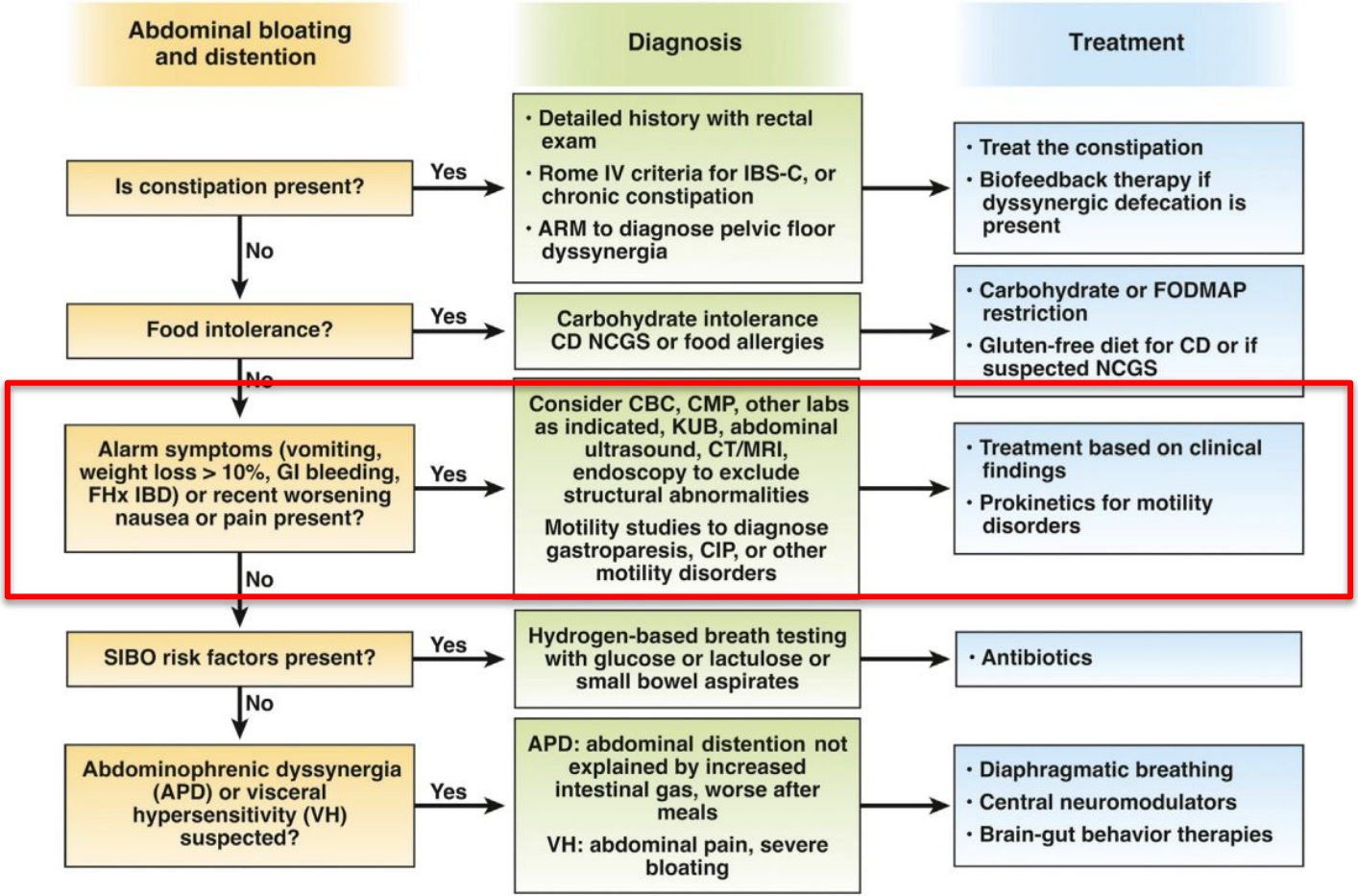
Disorders of Gut-Brain Interaction
-Irritable bowel syndrome
-Chronic idiopathic constipation
-Pelvic floor dysfunction
-Functional dyspepsia
-Functional bloating



AGA Clinical Practice Update on Evaluation and Management of Belching, Abdominal Bloating, and Distention



Moshiree et al. 2023



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Moshiree et al. 2023

Alarm Symptoms

Recurrent nausea/vomiting

Unexplained anemia (specifically iron deficiency anemia)

Hematemesis (vomiting blood)

Weight loss (> 10%, unintentional)

Family history of gastroesophageal malignancy, inflammatory bowel disease (Crohn’s disease, ulcerative colitis), or celiac disease

Ascites (fluid build up in the abdomen), jaundice

Moshiree et al. 2023

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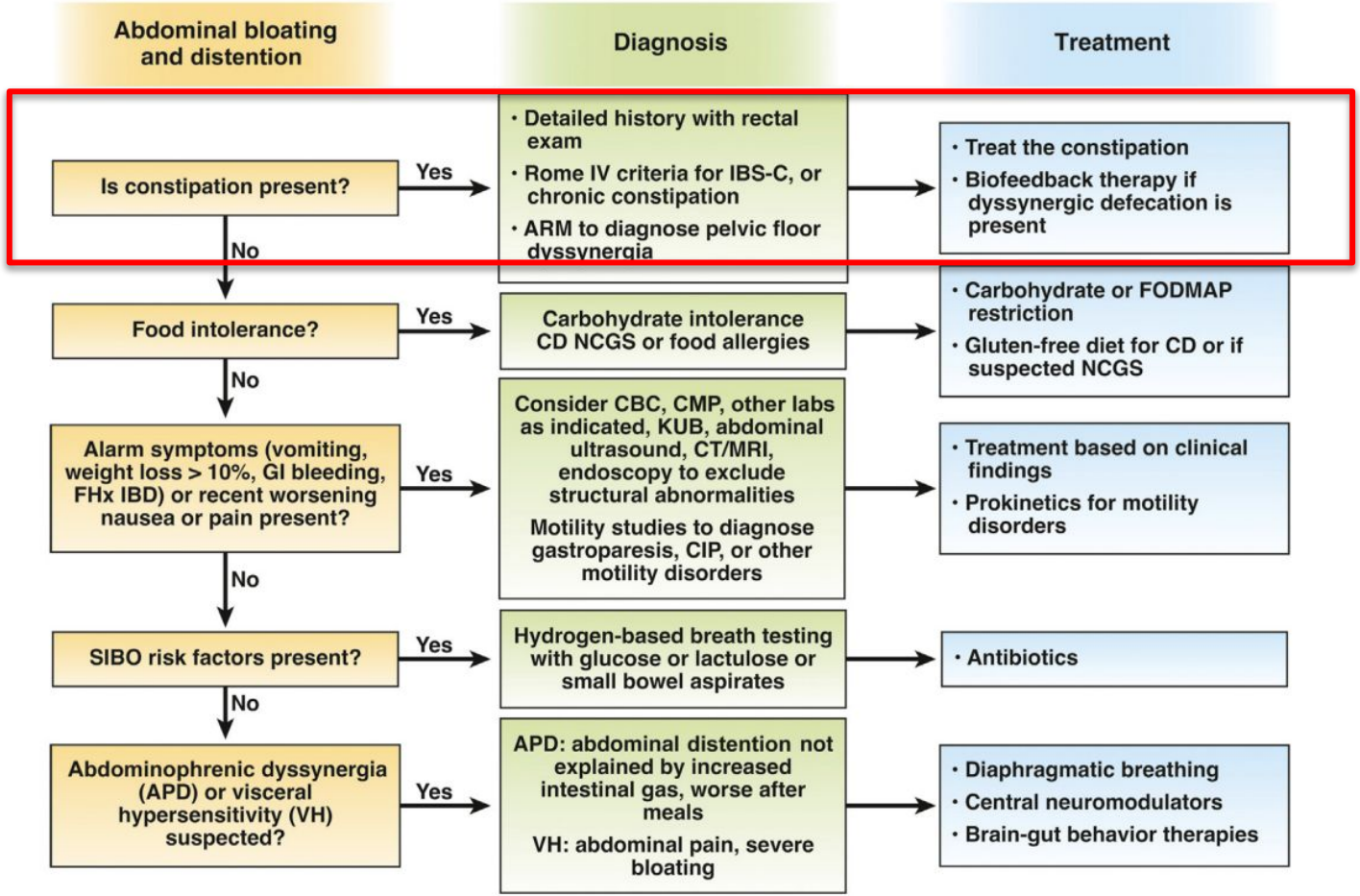

Moshiree et al. 2023

Treating Constipation

Slavin 2008
Borre et al. 2015
Dukas et al. 2003
Bharucha et al. 2020

IBS-C Rx Medications → referral to gastroenterologist

or **Pelvic Floor Therapies** → referral to pelvic floor physical therapist

Stimulant Laxatives → sennaside, bisacodyl

Osmotic Laxatives → polyethylene glycol (PEG), high Mg

3 F's → fiber, fluids, "fitness"

Nutritional Considerations in Constipation

Help the client understand that food is NOT driving the problem–motility and/or outlet dysfunction is! Major dietary changes are not helpful.

Minor changes to be considered:

- Increases in dietary fiber if woefully inadequate?
- Decreases in dietary fiber if intake is high and pelvic floor dysfunction appears present?
- Avoidance of inulin/chicory root and sugar alcohols until constipation is better managed?

Slavin 2008
Borre et al. 2015
Dukas et al. 2003
Bharucha et al. 2020
Müller-Lissner et al. 2005
Ho et al. 2012

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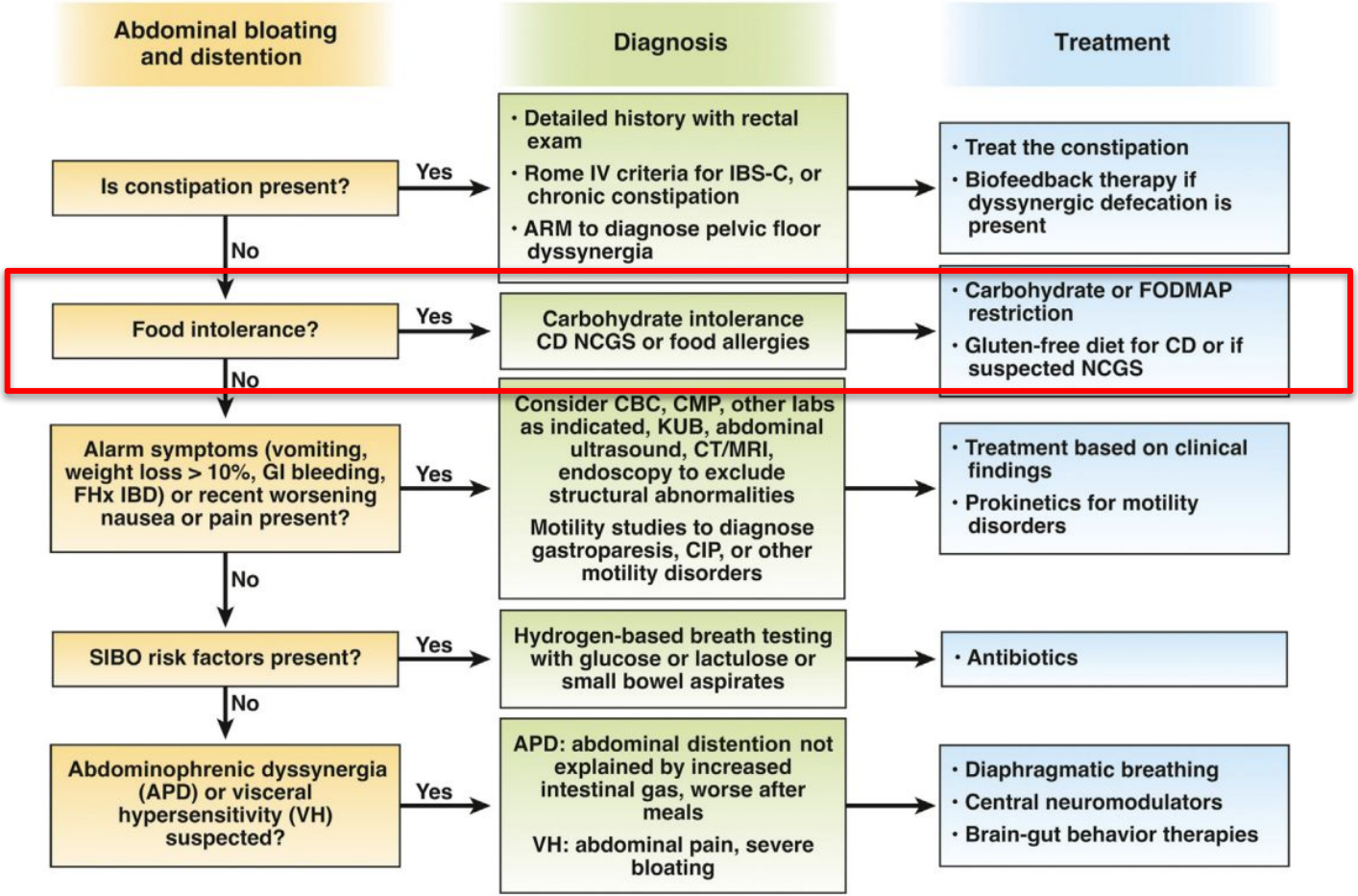

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Risks of Elimination Diets (including Low-FODMAP)

Elimination diets are considered contraindicated for people with EDs

- Individuals with “diet-related chronic health conditions” (including IBS) are at increased risk of developing DE/ED compared to healthy controls
- In patients following the low-FODMAP diet for IBS management, high dietary adherence doubled the individual’s ED risk
- GI patients with a self-reported history of participating in an exclusion diet were more than 3 times as likely to meet criteria for ARFID

Quick et al. 2013
Conviser et al. 2018
Mari et al. 2019
Atkins et al. 2023

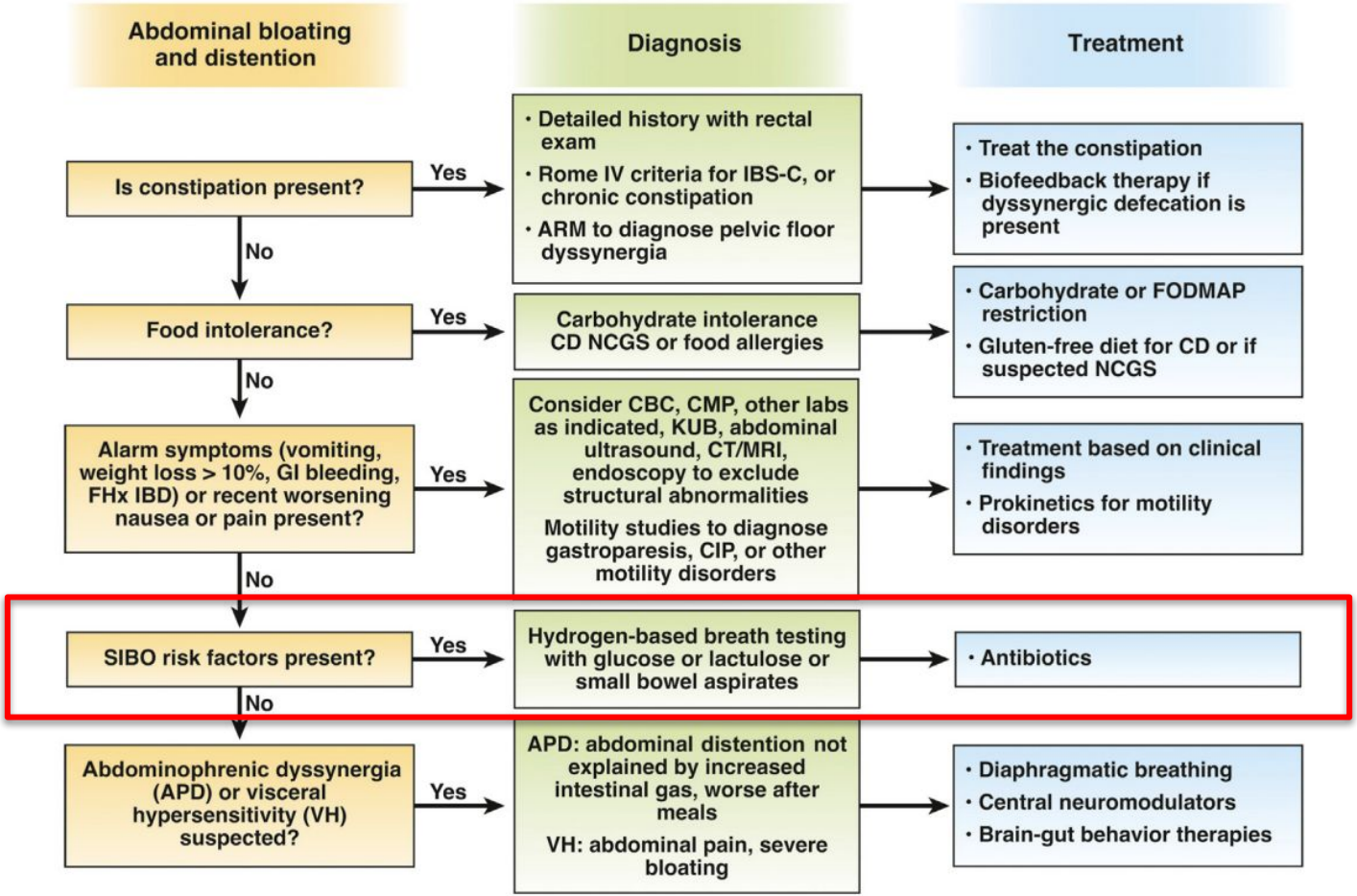
Sussing Out Food Intolerances

Have a solid hypothesis

Consider alternatives to broad food elimination

- Trial a suitable digestive enzyme to test your theory (e.g. lactase in the case of suspected lactose intolerance, glucose isomerase for fructose intolerance, etc.)
- “Cherry pick” a small selection of foods to take out of the diet on a trial basis IF they fit the overarching hypothesis and appear often (e.g. cauliflower rice/cauliflower pizza crust/cauliflower gnocchi)

Offer appropriate swaps for any foods removed!



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Small Intestinal Bacterial Overgrowth (SIBO) and Intestinal Methanogen Overgrowth (IMO)

What is it?

- Excess of bacteria in the small intestinal (SIBO) or excess archaea throughout the intestines (IMO) that ferment foods eaten into gases and substances that cause pain and diarrhea

Causes

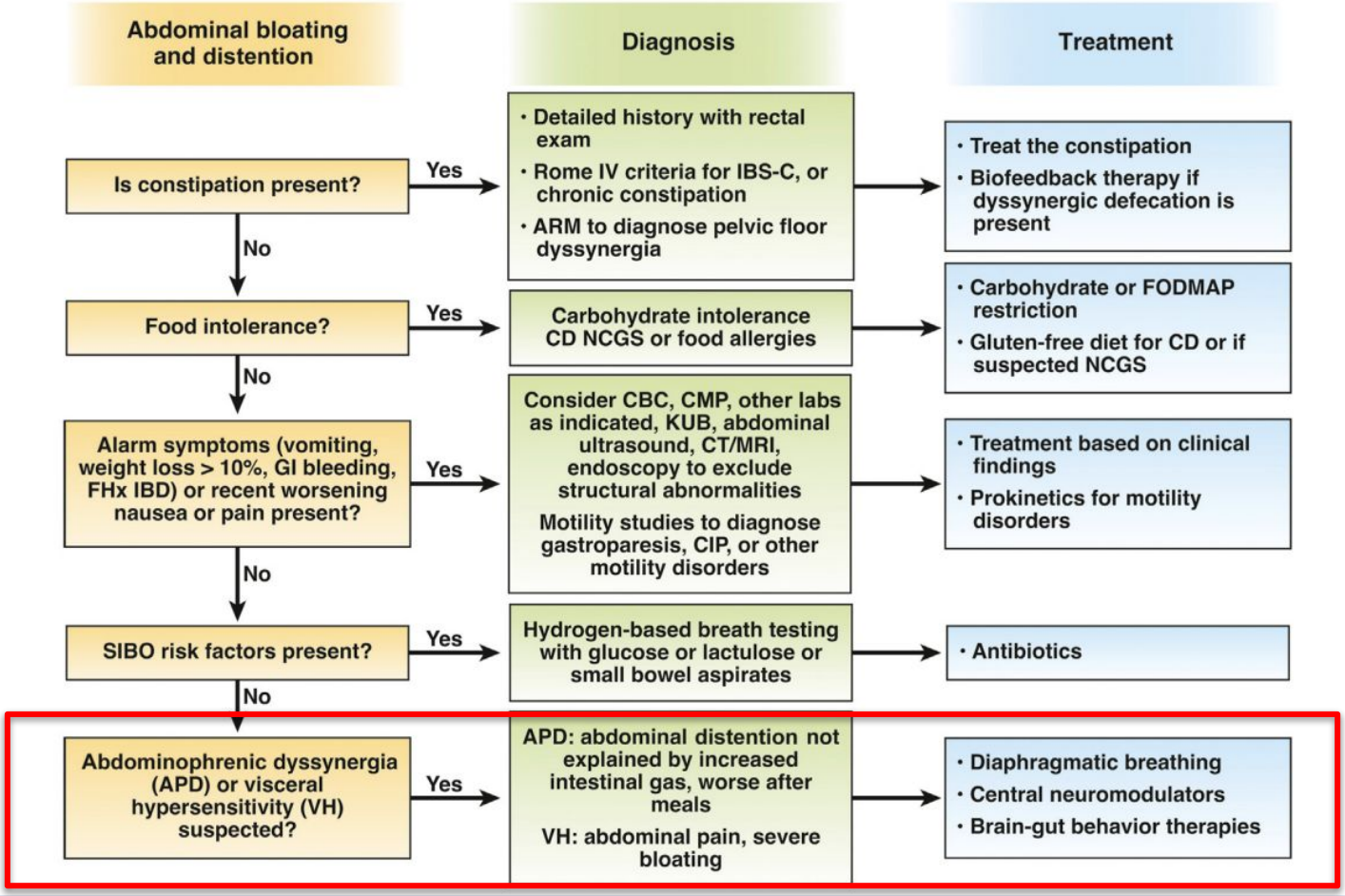
- Classic: post-surgical, motility disorders

Diagnosis

- Gold standard upper endoscopy with jejunal aspirates for culture
- More commonly by breath tests using a carbohydrate substrate (e.g., glucose, lactulose) and measuring gases (e.g., hydrogen, methane, and/or hydrogen sulfide) in the breath

Treatment using antibiotics

- SIBO: rifaximin
- IMO: rifaximin + neomycin
- Hydrogen sulfide: bismuth subsalicylate



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Moshiree et al. 2023

Abdomino-phrenic Dyssynergia (APD)

What is APD?

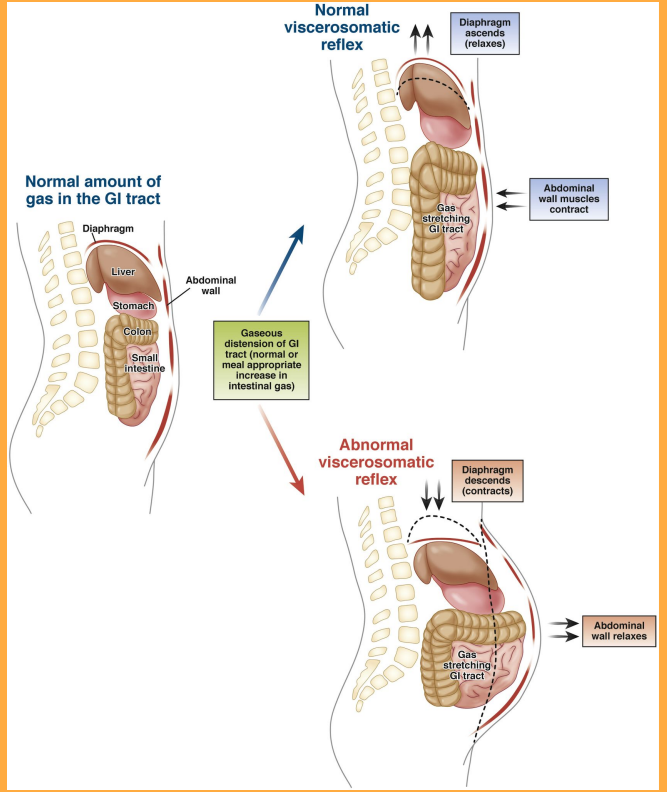
- Many individuals with bloating and distention do not have increased intestinal gas volumes.
- APD is the pathologic contraction and descent of the diaphragm and relaxation and protrusion of the abdominal wall.

Diagnosis

- No standardized testing.

Treatment

- EMG biofeedback, diaphragmatic breathing, treating associated DGBIs



Damianos et al. 2023

APD and VH Nutrition Strategies

Small, frequent meals to lessen stomach stretch

Make texture modifications to address bulk and slowed gastric emptying from insoluble fiber sources

- Peel and deseed
- Blenderize
- Cook until fork tender
- Chew well

Have fluids separate from meals to avoid crowding out needed nutrition

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