Dietary therapies in IBS: Where we are now and where do we go from here

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Learning Objectives

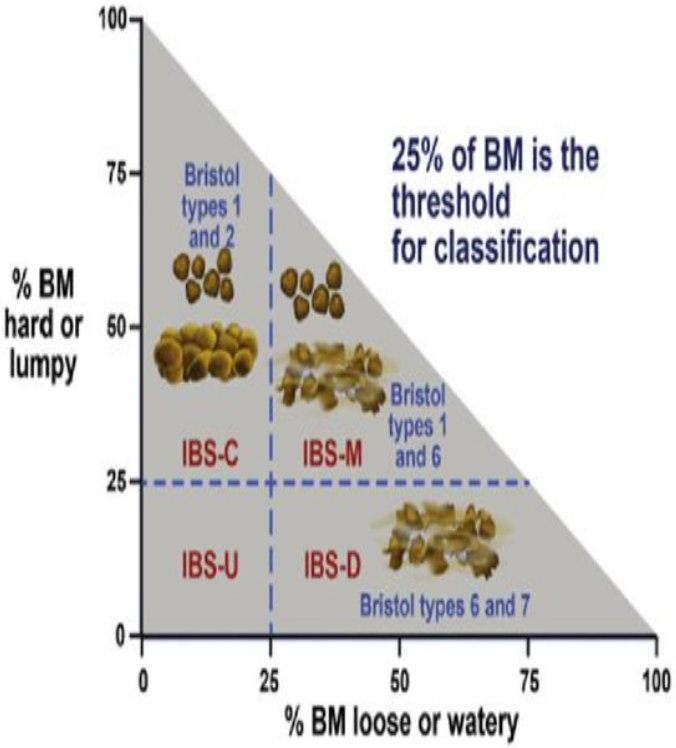
- Determine the who, when, how, and why when using the Low FODMAP diet in IBS.
- Other dietary therapies in IBS (old and new).
- The use of fiber and functional foods in IBS

IBS definition

Rome IV Criteria for IBS

Recurrent abdominal pain
at least 1 day/ week meeting 2/3 criteria

1. Related to defecation
2. Associated with a change in stool frequency
3. Associated with a change in stool consistency



*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

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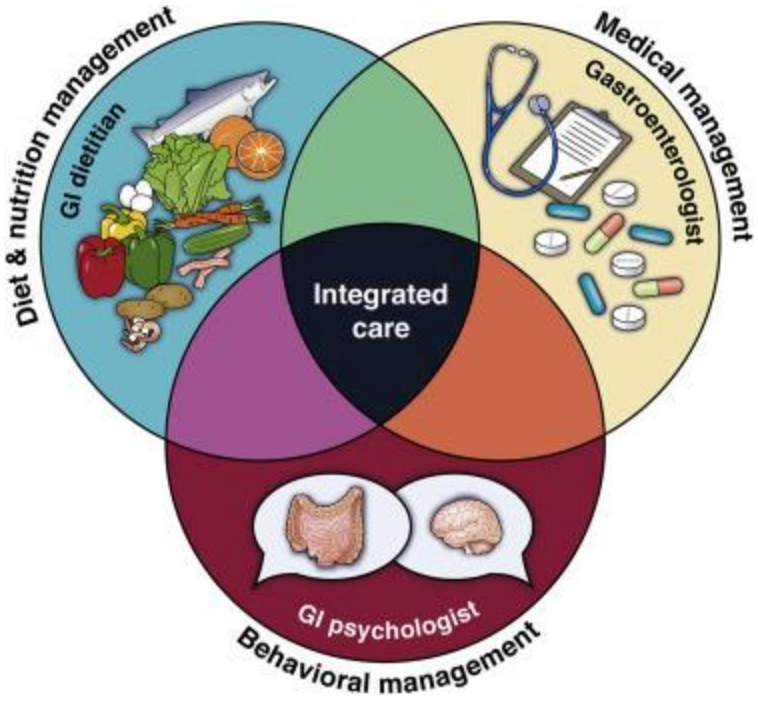
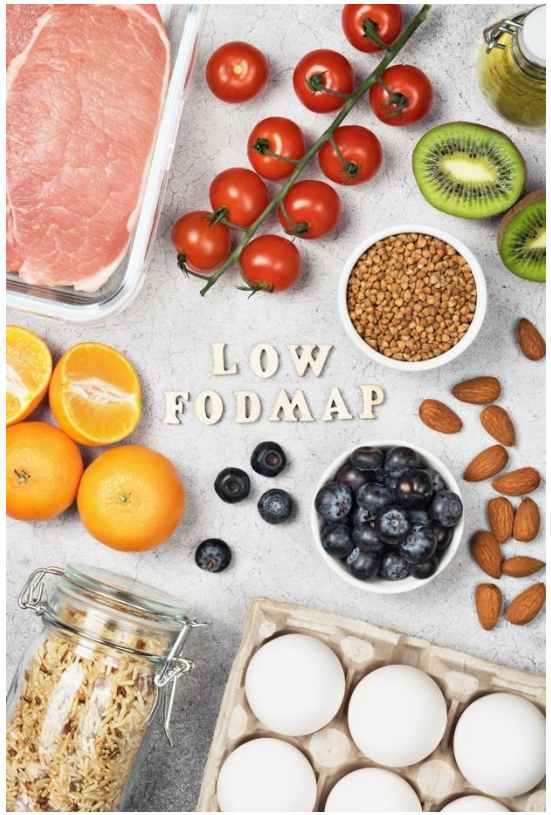
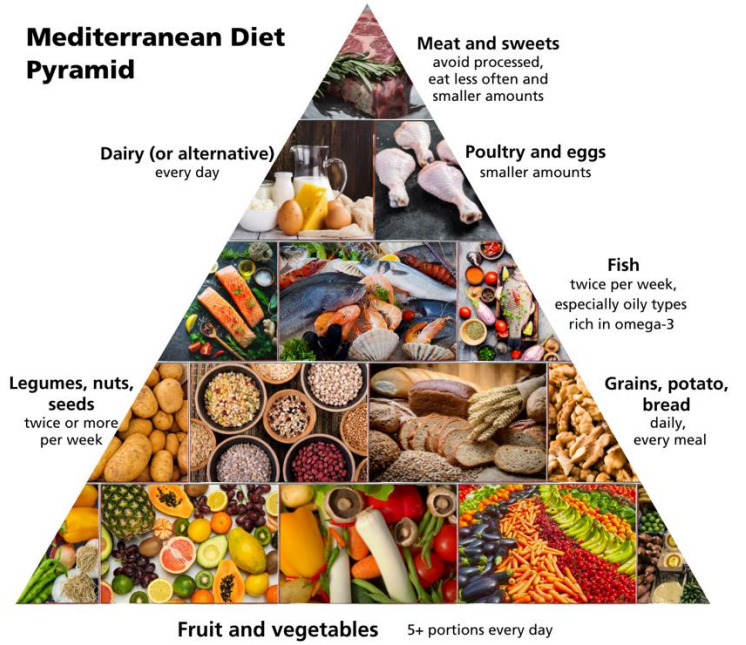
Rome Organization. Rome IV Disorders and Criteria.

Therapies for IBS







NICE National Institute for Health and Care Excellence

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Irritable bowel syndrome in adults: diagnosis and management

Clinical guideline [CG61] Published: 23 February 2008 Last updated: 04 April 2017

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PHASE 1 Reduce total FODMAP intake

Dietitian review

- Reduce FODMAP intake
- 2-8 weeks
- Replace with suitable low FODMAP alternatives from the same food group

If no response occurs return to usual diet and trial alternate treatment

PHASE 2 Re-challenge to assess tolerance

Dietitian review

Individual re-challenge of each FODMAP subgroup:

- Fructan e.g. wheat, onion
- GOS e.g. legumes/pulses
- Lactose e.g milk
- Excess fructose e.g. Honey
- Polyols e.g. avocado

Challenge over 2-3 days and monitor symptom response.
Order of challenges based on nutritional need and patient preferences.

PHASE 3 Long term maintenance

Dietitian review

Individualised diet based on response to food challenges:

- Tolerated foods – reintroduce freely
- Foods causing mild/moderate symptoms – reintroduce when able
- Foods causing severe symptoms – avoid

Continue to challenge poorly tolerated foods in the long-term

Learning Objectives

- Why use it?
- When to use it (and when not to)
- How to use it?
- How does it work?
- Who should we use it in?

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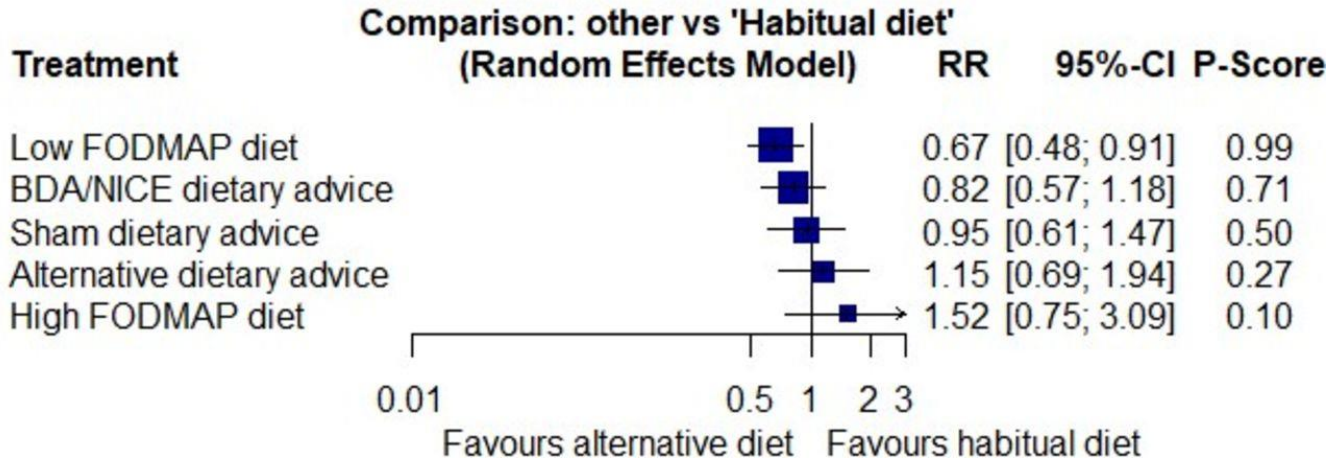
Efficacy of LFD in IBS: A network meta-analysis



Low FODMAP diet					
0.81 (0.67 to 0.97)	BDA/NICE dietary advice				
0.70 (0.52 to 0.95)	0.87 (0.61 to 1.23)	Sham dietary advice			
0.67 (0.48 to 0.91)	0.82 (0.57 to 1.18)	0.95 (0.61 to 1.47)	Habitual diet		
0.58 (0.38 to 0.87)	0.71 (0.45 to 1.12)	0.82 (0.49 to 1.37)	0.87 (0.52 to 1.46)	Alternative dietary advice	
0.44 (0.23; 0.83)	0.54 (0.28 to 1.05)	0.62 (0.31 to 1.26)	0.66 (0.32 to 1.34)	0.76 (0.36 to 1.62)	High FODMAP diet

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Black et al, Gut 2021

Efficacy of LFD IBS: A network meta-analysis (contd.)

Table 3 Summary treatment effects from the network meta-analysis for failure to achieve an improvement in abdominal pain severity

Low FODMAP diet					
0.79 (0.39 to 1.59)	**Alternative dietary advice**				
0.78 (0.57 to 1.06)	0.98 (0.46 to 2.11)	**BDA/NICE dietary advice**			
0.72 (0.47 to 1.10)	0.91 (0.40 to 2.06)	0.92 (0.54 to 1.57)	**Habitual diet**		
0.51 (0.30 to 0.87)	0.65 (0.27 to 1.56)	0.66 (0.35 to 1.22)	0.71 (0.36 to 1.41)	**Sham dietary advice**	
0.47 (0.20 to 1.07)	0.59 (0.20 to 1.74)	0.60 (0.25 to 1.45)	0.65 (0.26 to 1.65)	0.91 (0.34 to 2.44)	**High FODMAP diet**

Relative risk with 95% CIs in parentheses. Comparisons, column versus row, should be read from left to right and are ordered relative to their overall efficacy. The intervention in the top left position is ranked as best after the network meta-analysis of direct and indirect effects. Boxes shaded green denote a statistically significant difference.
BDA/NICE, British Dietetic Association/National Institute for Health and Care Excellence; FODMAP, fermentable oligosaccharides, disaccharides, monosaccharides, and polyols.

Table 4 Summary treatment effects from the network meta-analysis for failure to achieve an improvement in abdominal bloating or distension severity

Low FODMAP diet					
0.95 (0.50 to 1.79)	**Alternative dietary advice**				
0.85 (0.51 to 1.43)	0.90 (0.40 to 2.05)	**Sham dietary advice**			
0.69 (0.36 to 1.32)	0.73 (0.29 to 1.81)	0.81 (0.35 to 1.86)	**High FODMAP diet**		
0.72 (0.55 to 0.94)	0.76 (0.38 to 1.52)	0.84 (0.47 to 1.52)	1.05 (0.51 to 2.13)	**BDA/NICE dietary advice**	
0.71 (0.47 to 1.06)	0.75 (0.35 to 1.59)	0.83 (0.43 to 1.60)	1.03 (0.48 to 2.22)	0.98 (0.61 to 1.60)	**Habitual diet**

Relative risk with 95% CIs in parentheses. Comparisons, column versus row, should be read from left to right and are ordered relative to their overall efficacy. The intervention in the top left position is ranked as best after the network meta-analysis of direct and indirect effects. Boxes shaded green denote a statistically significant difference.
BDA/NICE, British Dietetic Association/National Institute for Health and Care Excellence; FODMAP, fermentable oligosaccharides, disaccharides, monosaccharides, and polyols.

- LFD ranked first for abdominal pain severity, abdominal bloating severity, and bowel habit
- The magnitude of improvement greatest for abdominal pain
- No difference in efficacy among various IBS subtypes

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Black et al, Gut 2021
Dean et al, ACG 2021

Learning Objectives

- Why use it?
- When to use it (and when not to)
- How to use it?
- How does it work?
- Who should we use it in?

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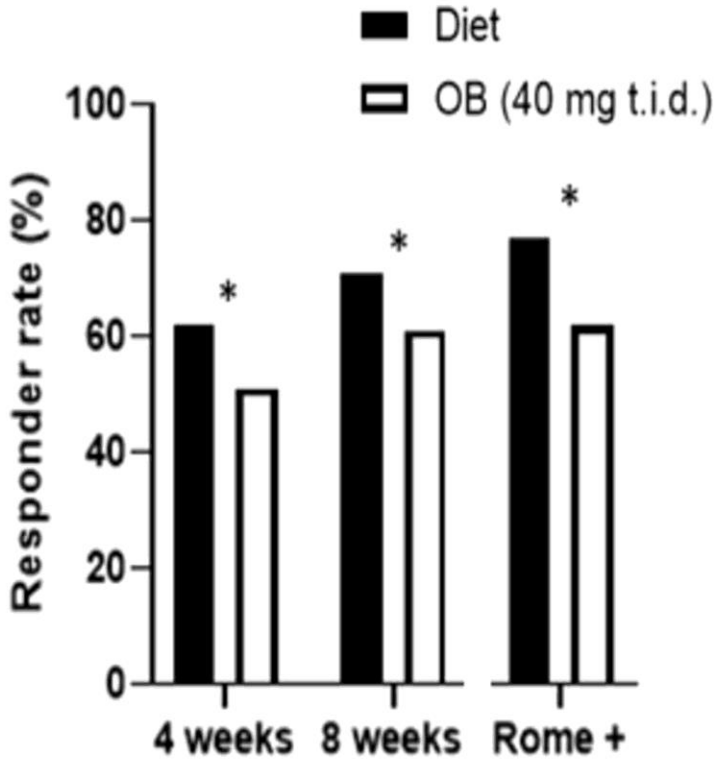
LFD as first-line therapy in IBS?

- 459 primary care IBS patients randomized to Otilonum bromide vs. LFD
- A 50-point decrease in IBS-SSS as a response
- The significantly higher response rate with diet after 4 and 8 weeks.
- In primary care IBS patients, LFD was superior to a spasmolytic agent in improving IBS symptoms.



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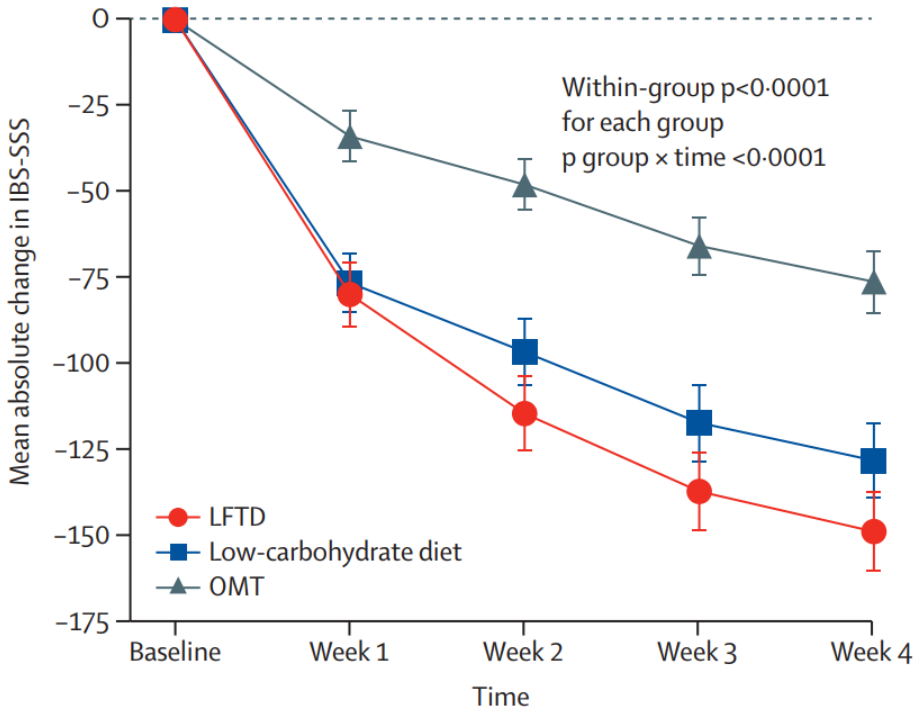
Carbone et al, Gut 2022

LFD as first-line therapy in IBS?

- Single center, single-blind, RCT
- N=304
- Primary outcome = 50-point IBS-SSS reduction
- LFD and low carbohydrate diet better than optimized medical therapy (76% vs. 71% vs. 58% respectively, p=0·023).
- LFD could be used as first-line therapy for IBS



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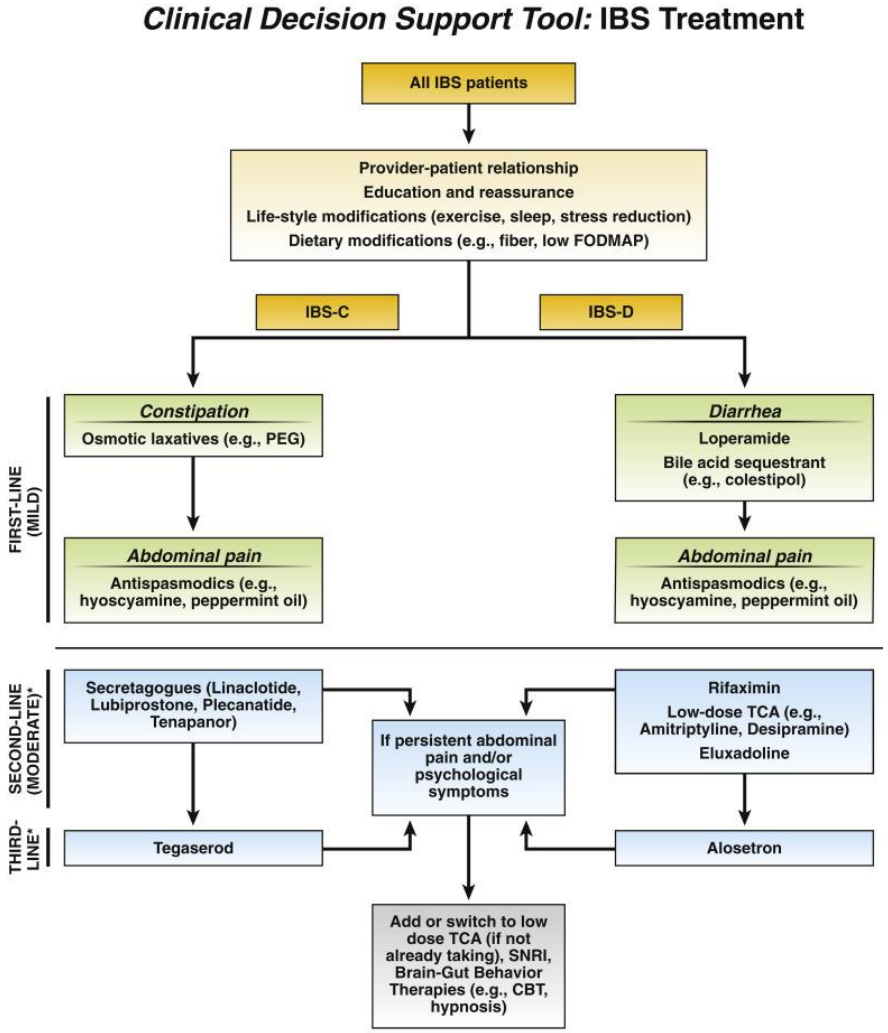
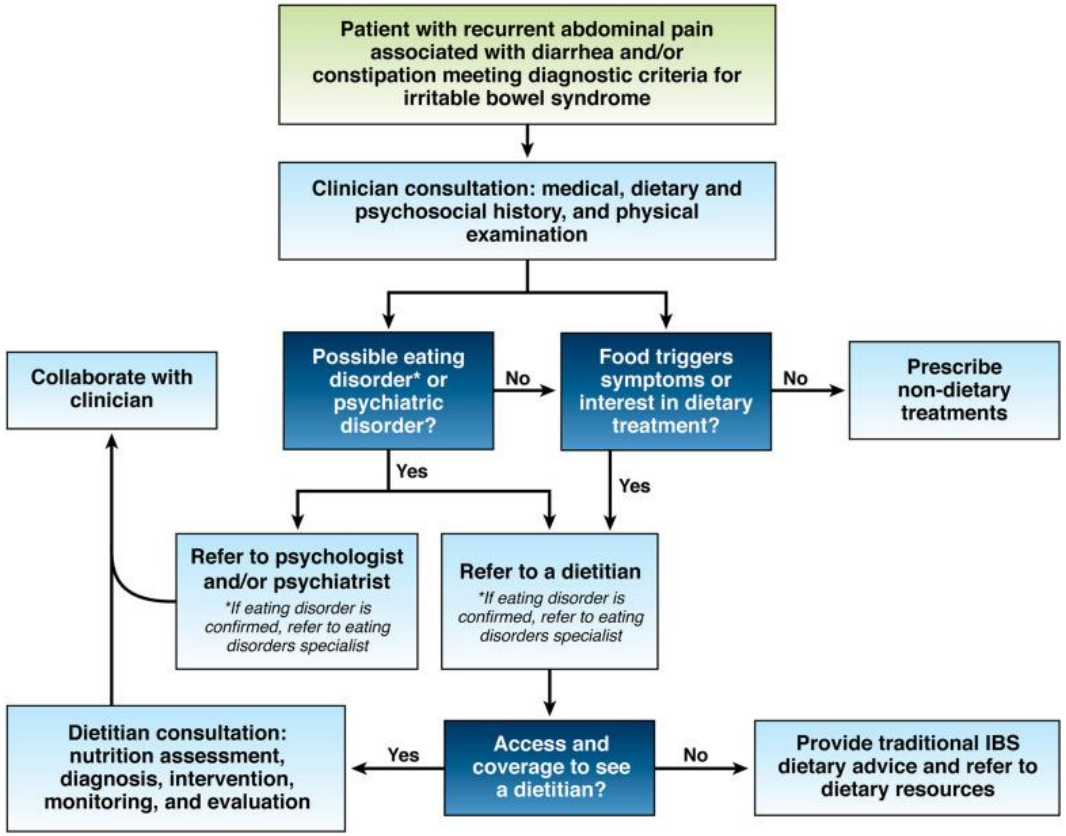
Nybacka et al, Lancet Gastro Hep 2024

When to use LFD?





Chang et al, Gastro 2022
Lembo et al, Gastro, 2022
Chey et al, Gastro 2022

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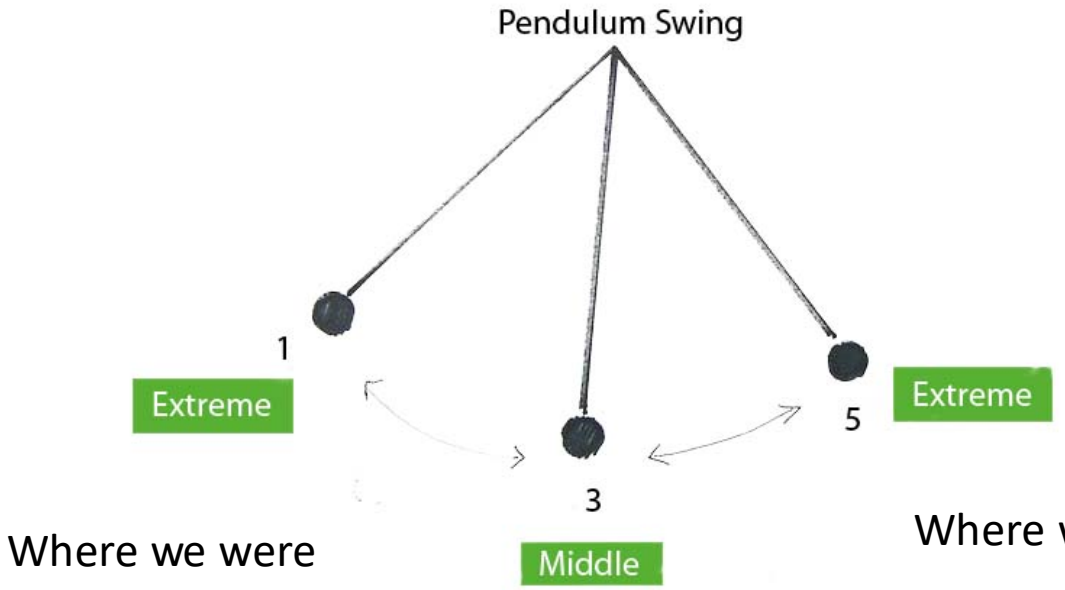
When not to use LFD

- Eating disorders including ARFID
- Already restricted diet
- Patient preference
- Cost
- Use with caution when constipation/diarrhea are the main complaint (Functional constipation, functional diarrhea)



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What's ARFID

- ARFID differs from other EDs in that it does *not* involve concerns about body shape or weight
- ARFID is defined as dietary restriction (reduced overall food intake and/or dietary variety) that results in one or more
  - ➢Nutritional deficiency,
  - ➢Significant weight loss/inability to gain weight
  - ➢Dependence on supplemental nutrition
  - ➢Impairment in psychosocial functioning.

ARFID contd.

- 20-25% of patients with DGBI likely have ARFID (can be up to 40%)
- Gastroenterologists must screen our patients for ARFID before introducing elimination diets
- Often open-ended questions are helpful
  - ✓How is your relationship with meals
  - ✓How is your appetite in general
  - ✓How is your weight doing
  - ✓Things they like/avoid to eat
- More specific questionnaires like SCOFF, NIAS, EDE-Q but their sensitivity and specificity in diagnosing ARFID in DGBI is not clear.

Learning Objectives

- Why use it?
- When to use it (and when not to)
- How to use it?
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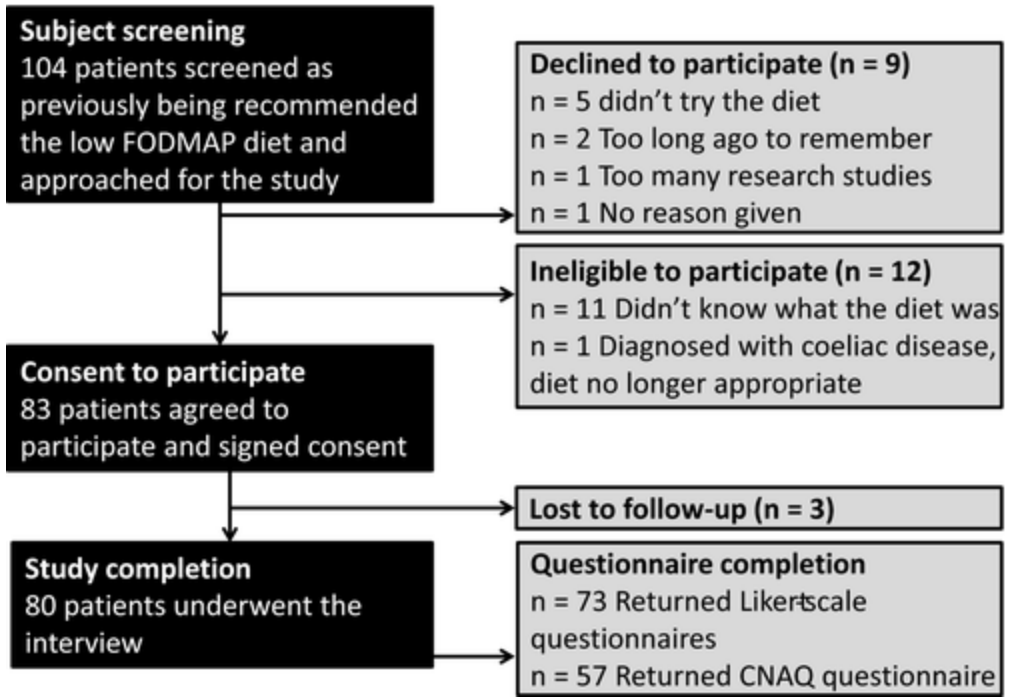
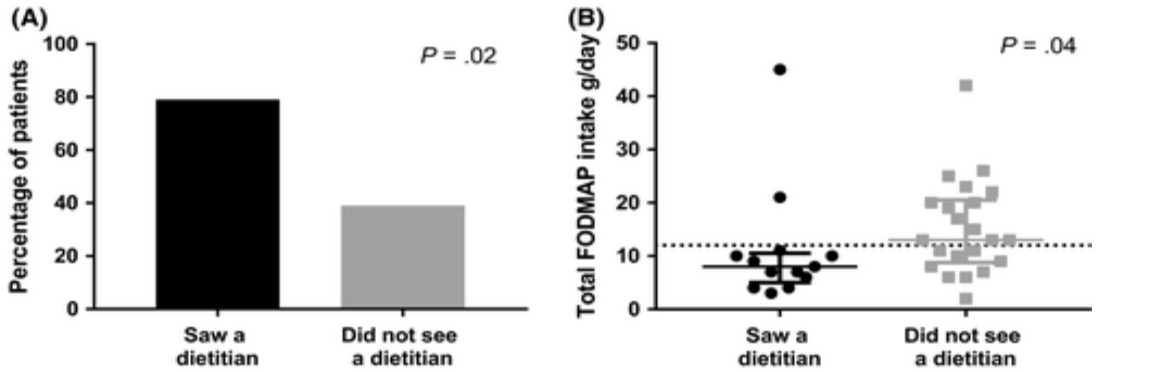
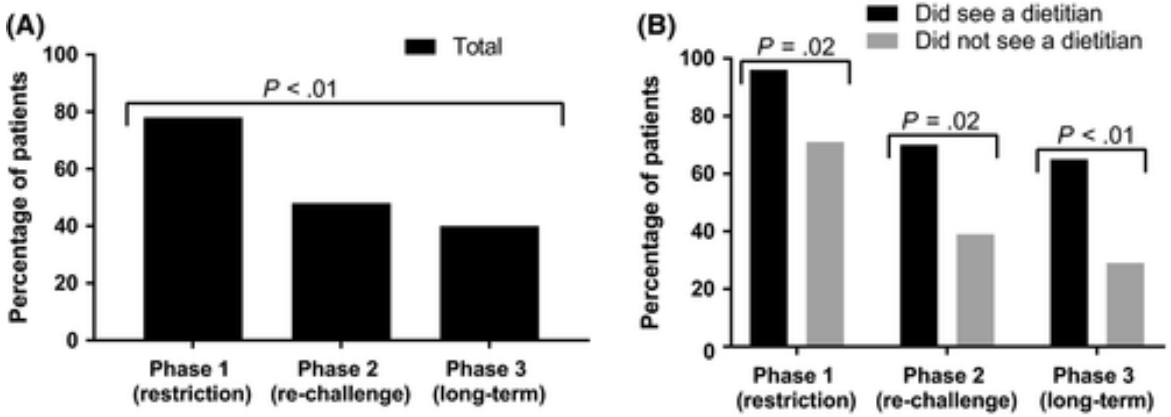
How to use LFD? (With a dietitian)







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Tuck et al, NGM, 2020

Patient experience with LFD

Figure 1

Figure 1a.

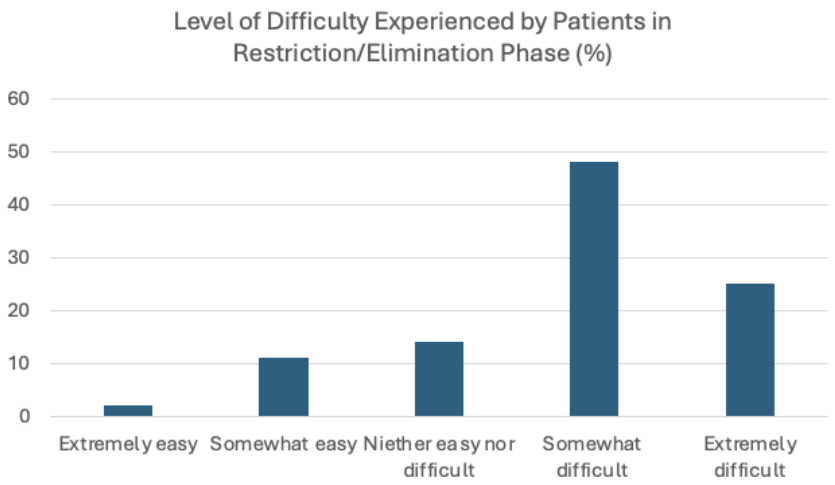


Figure 1b.

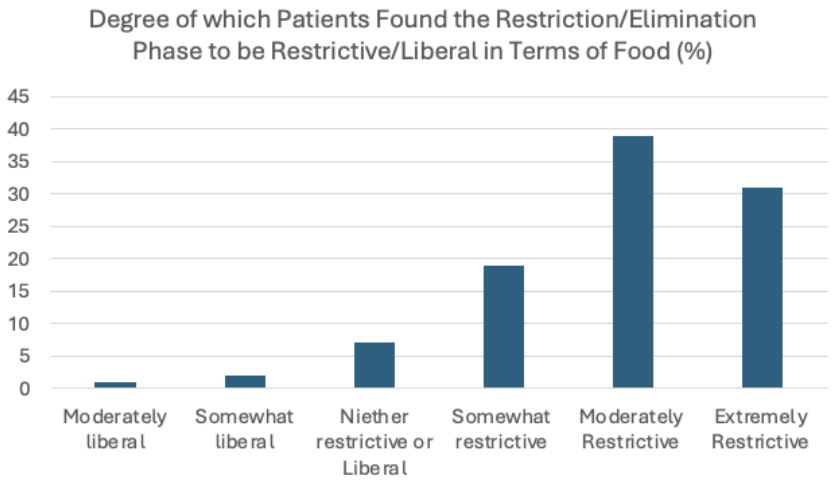


Figure 1c.

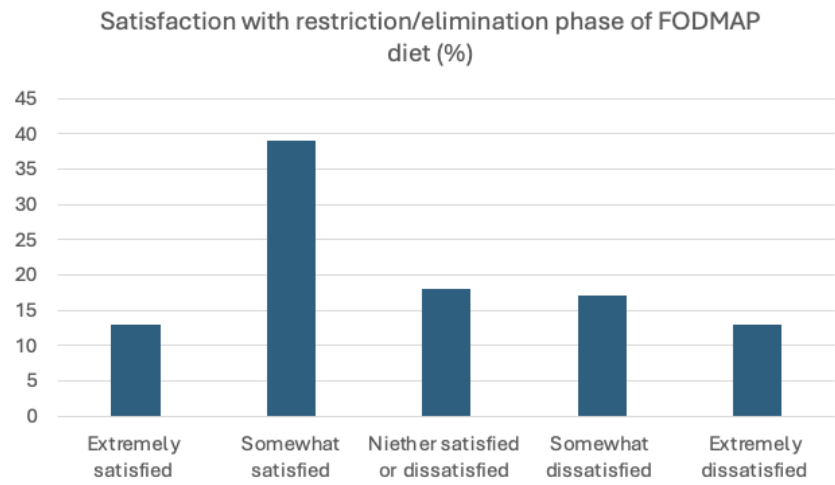
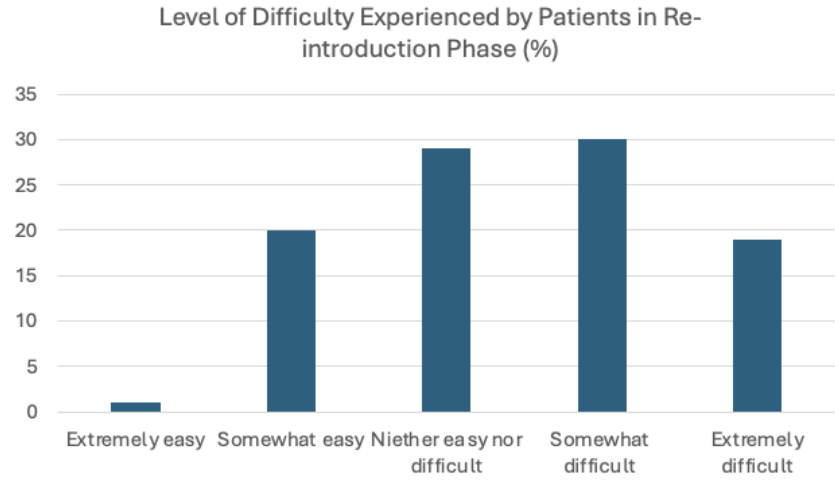


Figure 1d.



Singh et al, Unpublished data

Patient experience with LFD

Table 1

Number of patients	8 weeks or less	8-12 weeks	13-16 weeks	17-20 weeks	> 20 weeks
Time spent on the restriction/elimination phase of low FODMAP diet	32 (38%)	20 (24%)	7 (8%)	7 (8%)	18 (21%)
Time spent to complete re-introduction phase of low FODMAP diet	22 (33%)	17 (25%)	10 (15%)	4 (6%)	14 (21%)
	Yes		No		
Patients answering yes/no regarding if they are still in the personalization phase of the FODMAP diet	40 (53%)		35 (47%)		
	3 food items or less avoided	4-5 food items avoided	6-10 food items avoided	> 10 food items avoided	
Patients avoiding high FODMAP items in the personalization/maintenance phase	1 (3%)	9 (23%)	11 (28%)	19 (48%)	

Singh et al, Unpublished data

Cons of LFD

- Restrictive
- Cumbersome
- Time-consuming
- Costly
- Potential risk of continuing the elimination phase long-term
- Risk of micronutrient deficiencies

Identifying the most culprit FODMAP subgroups

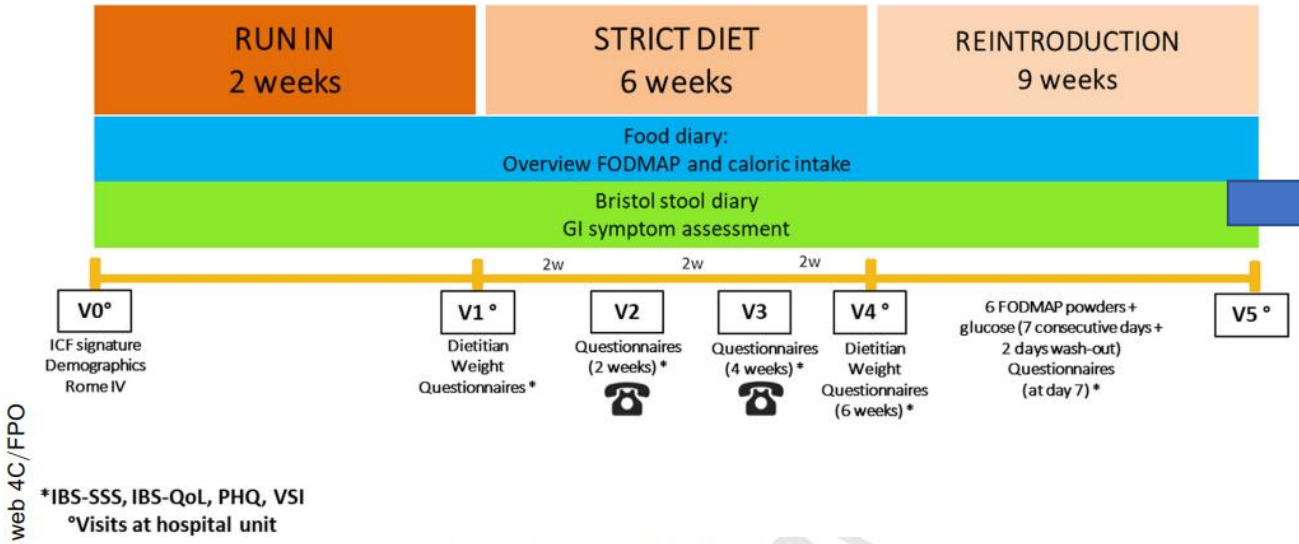
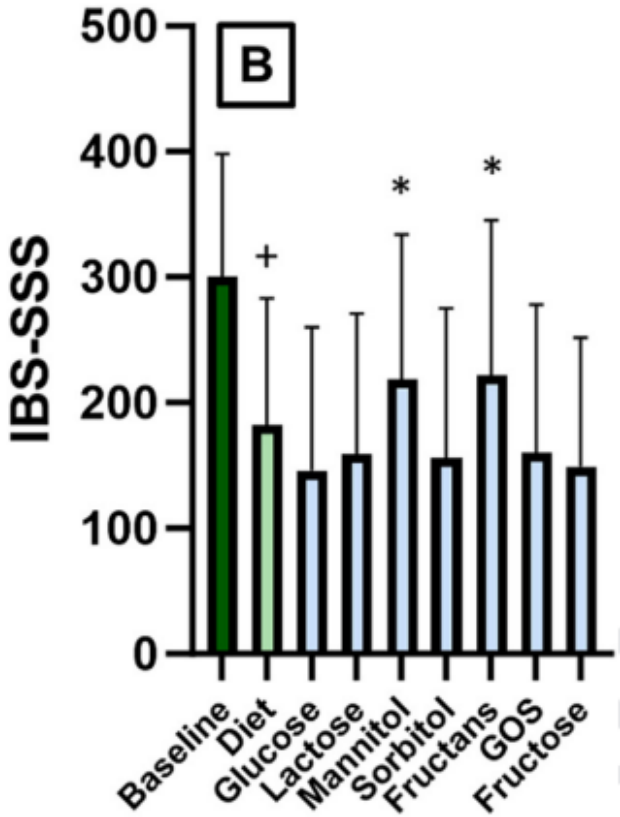


Figure 1. Trial design. GI, gastrointestinal.

Randomized blinded order	
Fructans	20g
Fructose	60g
GOS	12g
Lactose	60g
Mannitol	15g
Sorbitol	15g
Glucose	30g



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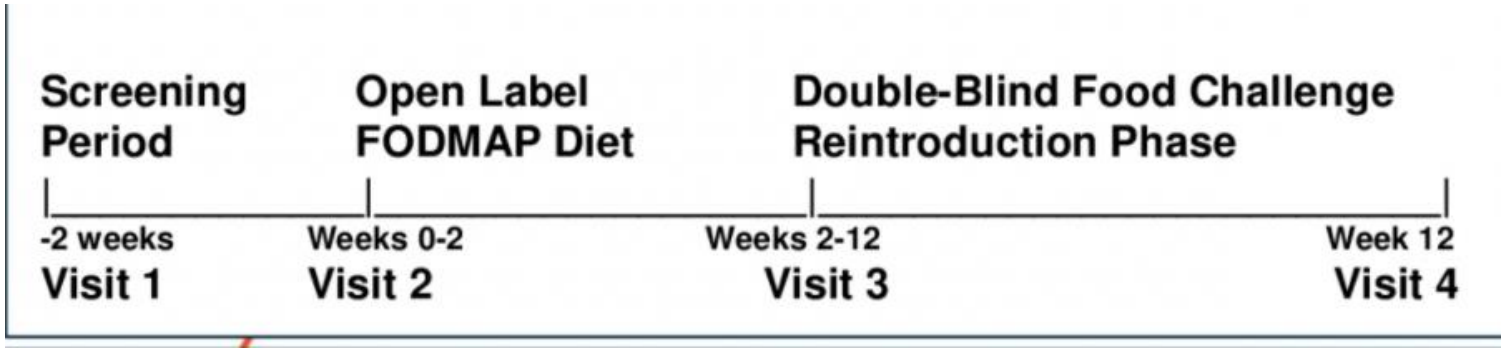
Van den Houte et al, Gastroenterology, 2024

Not all FODMAPs are equal



Double-blind Food Challenge

5 sequences over 7 days; 7-day washout

Challenge	3-day Moderate dose	4-day high dose
Fructans	0.75g	1.5g
Fructose	10g	21g
GOS	2g	4g
Lactose	10g	20g
Sorbitol	5g	10g

- Abdominal pain was significantly worse after fructans. (P=0.007)
- In analyses restricted to the first reintroduction period, the fructan (*P* =.03) and galactan (*P* =.04) challenges were significantly associated with abdominal pain.
- In analyses restricted to first reintroduction challenge, galactan (*P* =.03) was significantly associated with bloating.

Eswaran S, CGH 2024

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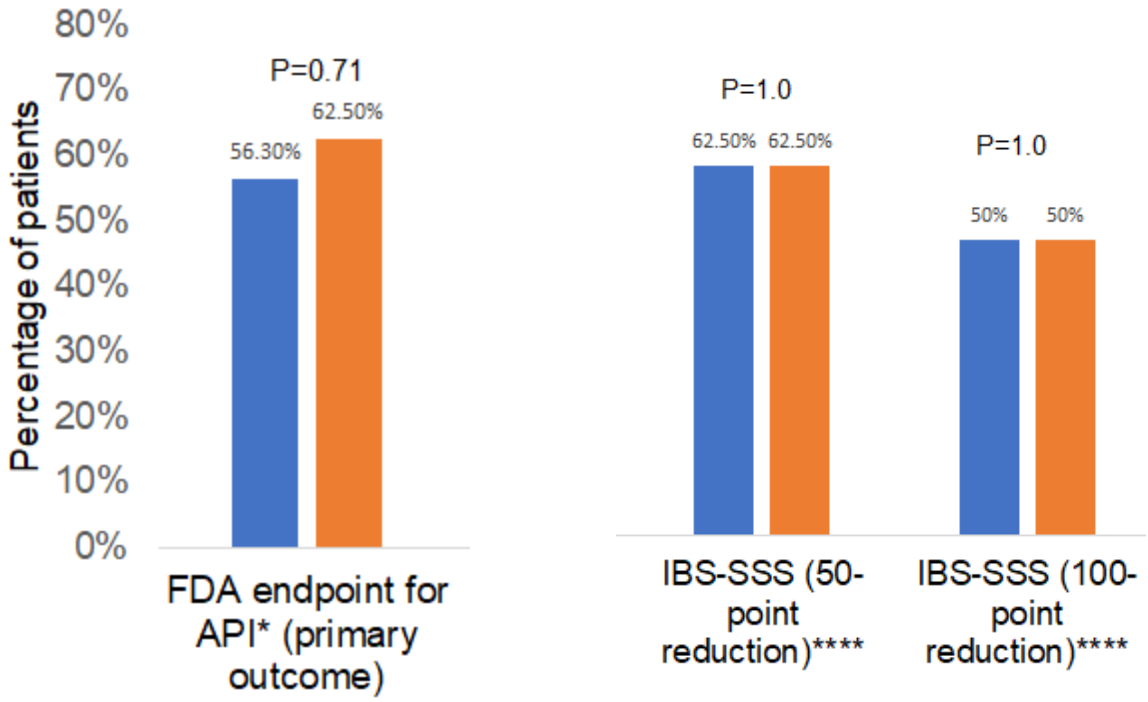
Simplified version of low fodmap restriction is feasible and effective

- Pilot, feasibility trial comparing FODMAP-simple (eliminating fructans and galacto-oligosaccharides) vs. traditional LFD in IBS-D
- FODMAP-simple improves symptoms in a majority of patients with IBS-D.
- FODMAP-simple is better tolerated than traditional LFD (AE rate 12.5% vs. 26.3%)



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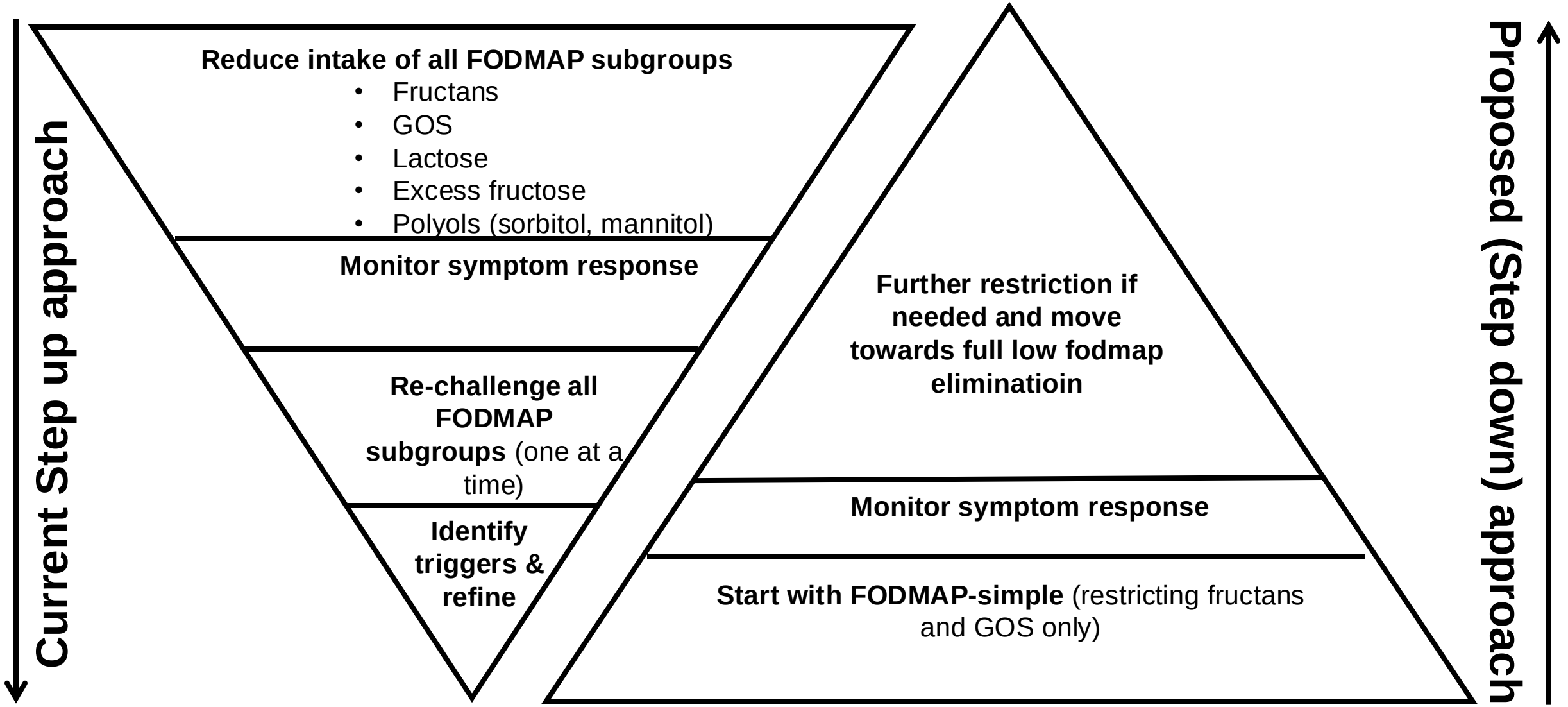
Singh et al, CGH 2024


Current Step up approach
Reduce intake of all FODMAP subgroups
• Fructans
• GOS
• Lactose
• Excess fructose
• Polyols (sorbitol, mannitol)
Monitor symptom response
Re-challenge all FODMAP subgroups (one at a time)
Identify triggers & refine
Proposed (Step down) approach
Further restriction if needed and move towards full low fodmap eliminatioin
Monitor symptom response
Start with FODMAP-simple (restricting fructans and GOS only)

Learning Objectives

- Why use it?
- When to use it (and when not to)
- How to use it?
- How does it work?
- Who should we use it in?

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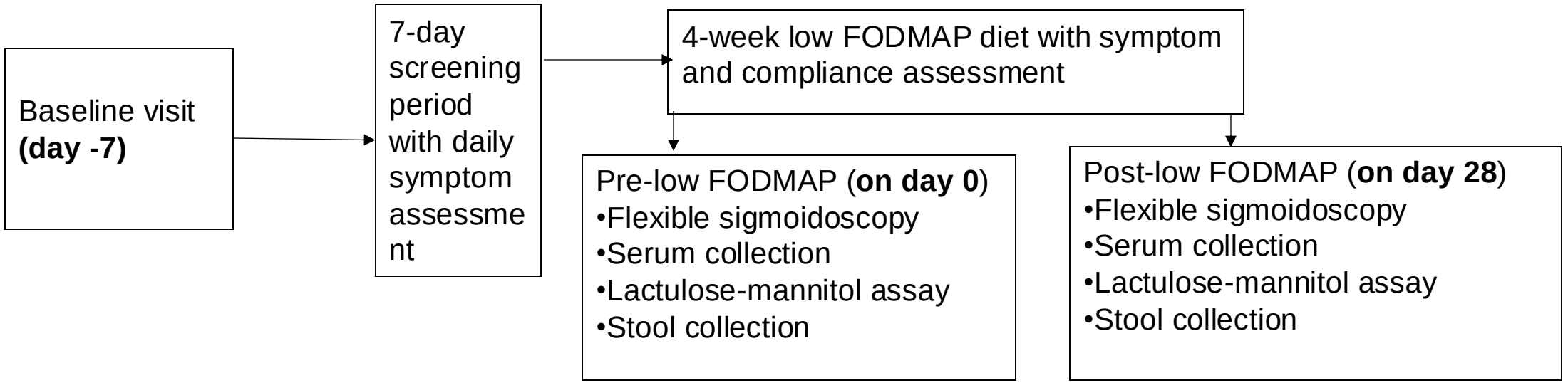
Aim: Delineate the effect of LFM on colonic epithelial barrier function and mast cell activation in IBS-D

Hypothesis: LFM improves colonic epithelial barrier function and decreases mast cell activation in IBS-D patients with response to LFM



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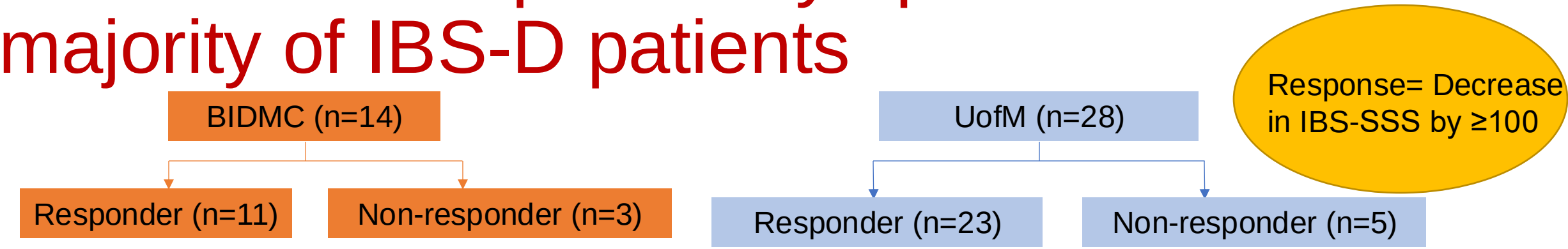
4-week LFM improves symptoms in majority of IBS-D patients



	Responders			Non-responders		
Change in clinical parameters	Pre-LFM (n=34)	Post-LFM (n=34)	P value	Pre-LFM (n=8)	Post-LFM (n=8)	P value
Mean IBS-SSS score	295.4	79.8	<0.001	235	232	0.87
Mean PROMIS abdominal pain score	62.5	38.8	0.002	64.5	61.8	0.18
Mean PROMIS diarrhea score	59.6	44.4	0.02	57.2	58.1	0.72
Mean weekly BSFS stool consistency	5.4	4.1	0.009	5.2	4.8	0.26

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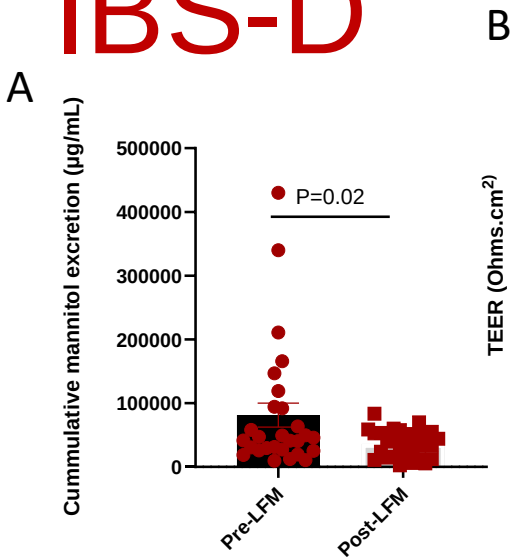
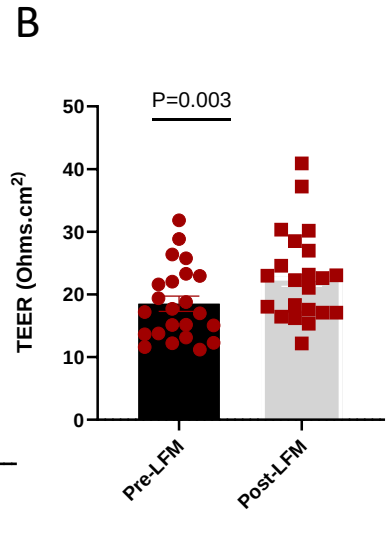
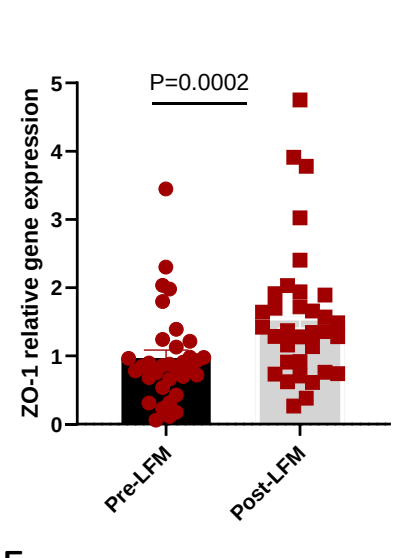
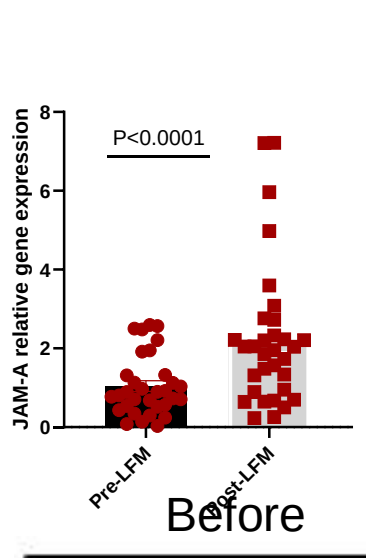
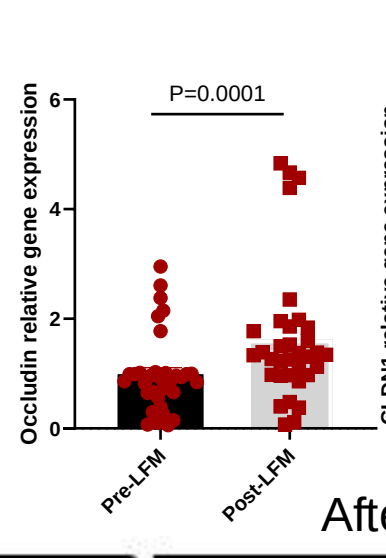
LFM improves barrier function in patients with IBS-D

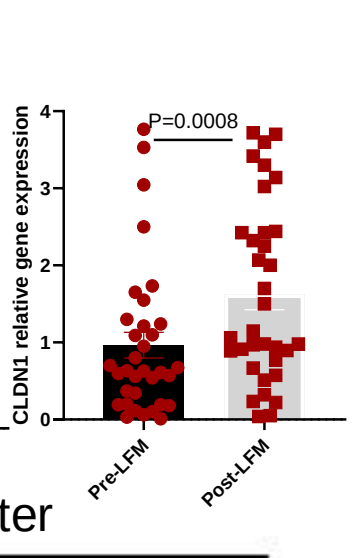


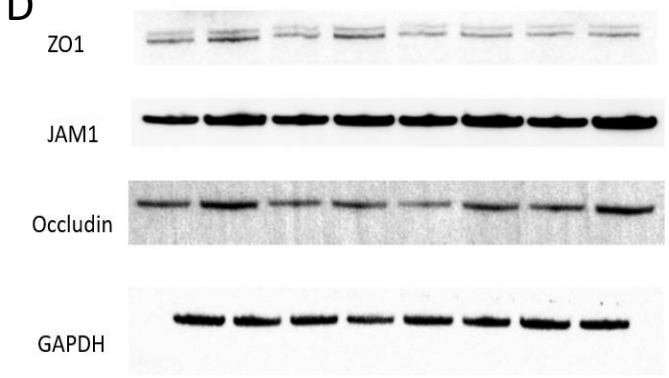


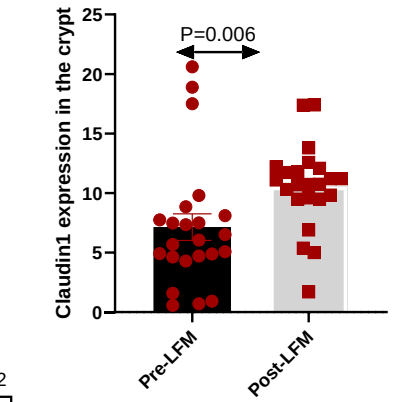






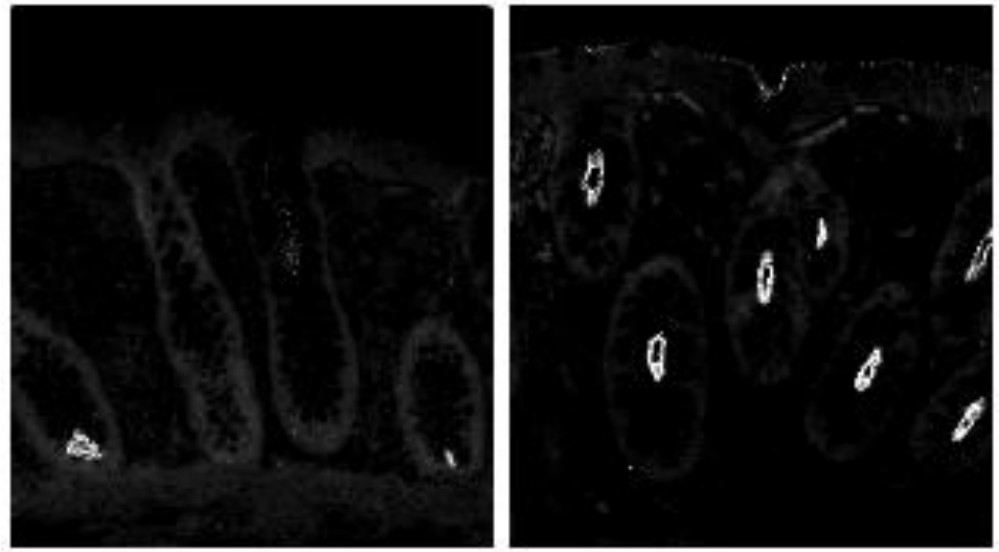


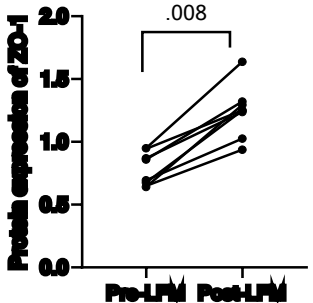


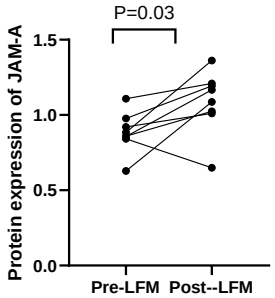


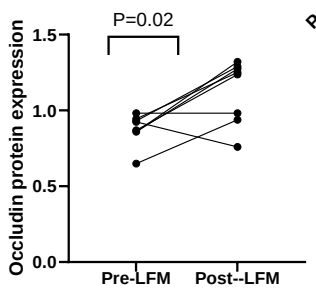
Before

After









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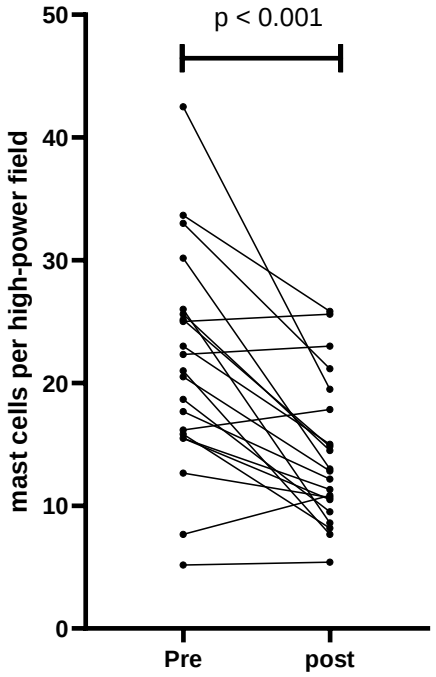
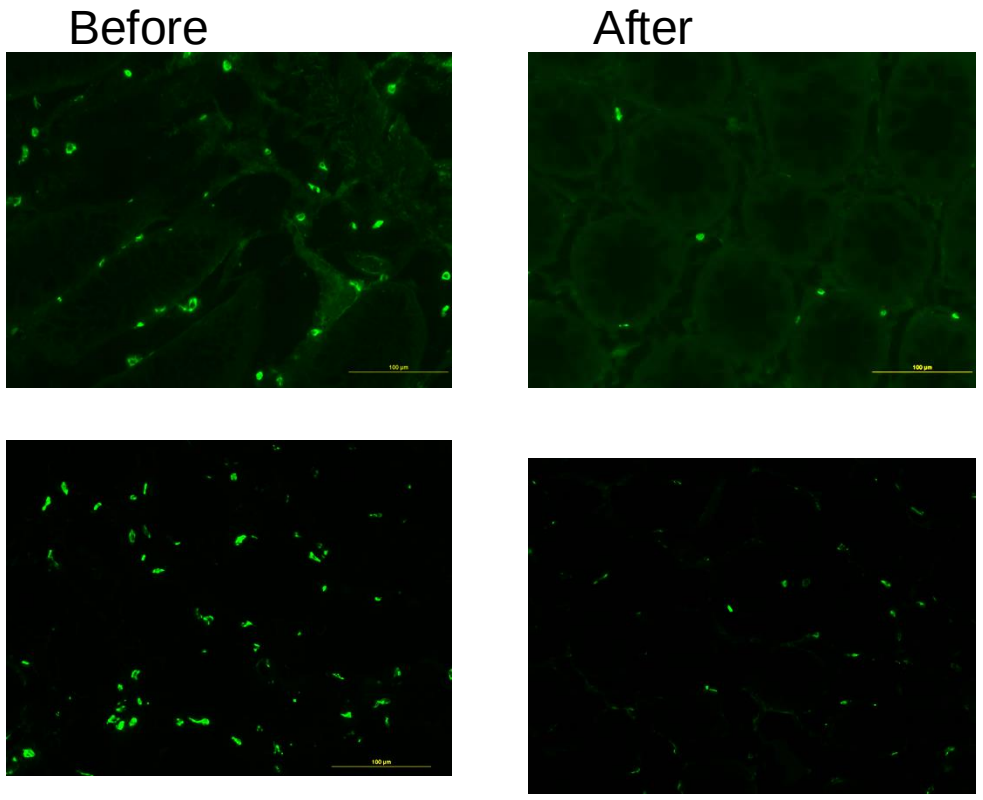
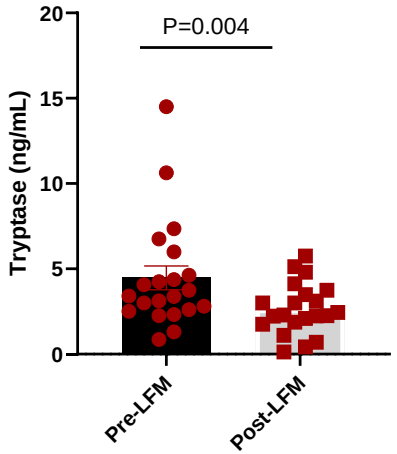
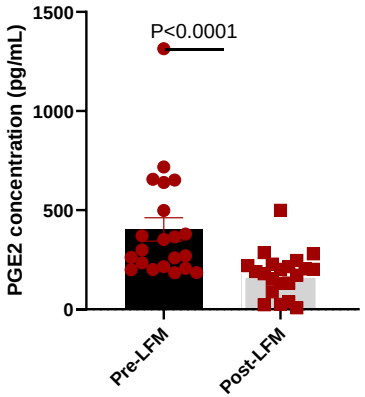
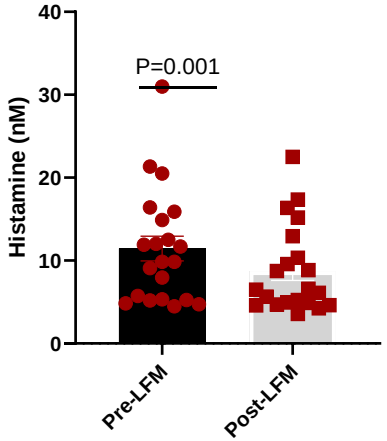
LFM improves colonic mast cell infiltration in IBS-D patients











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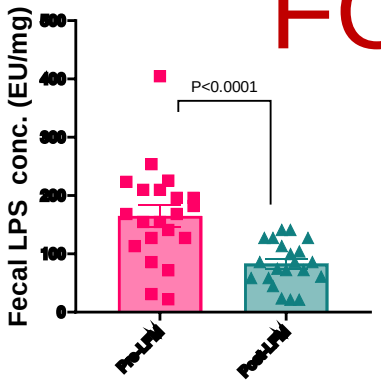
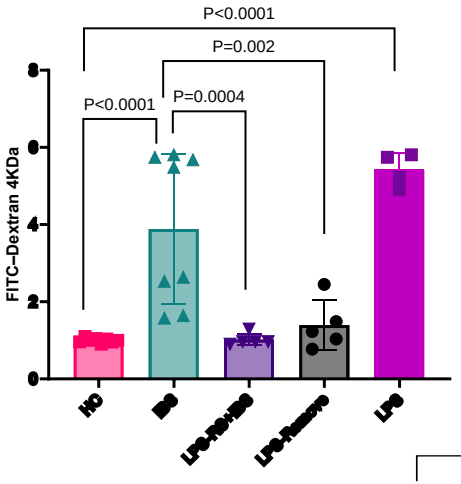
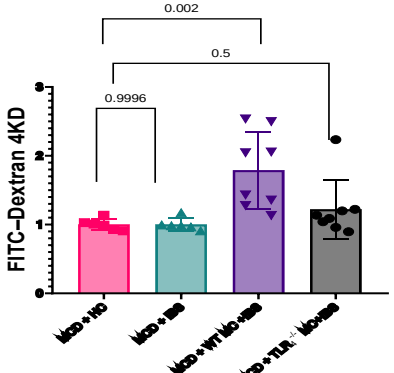
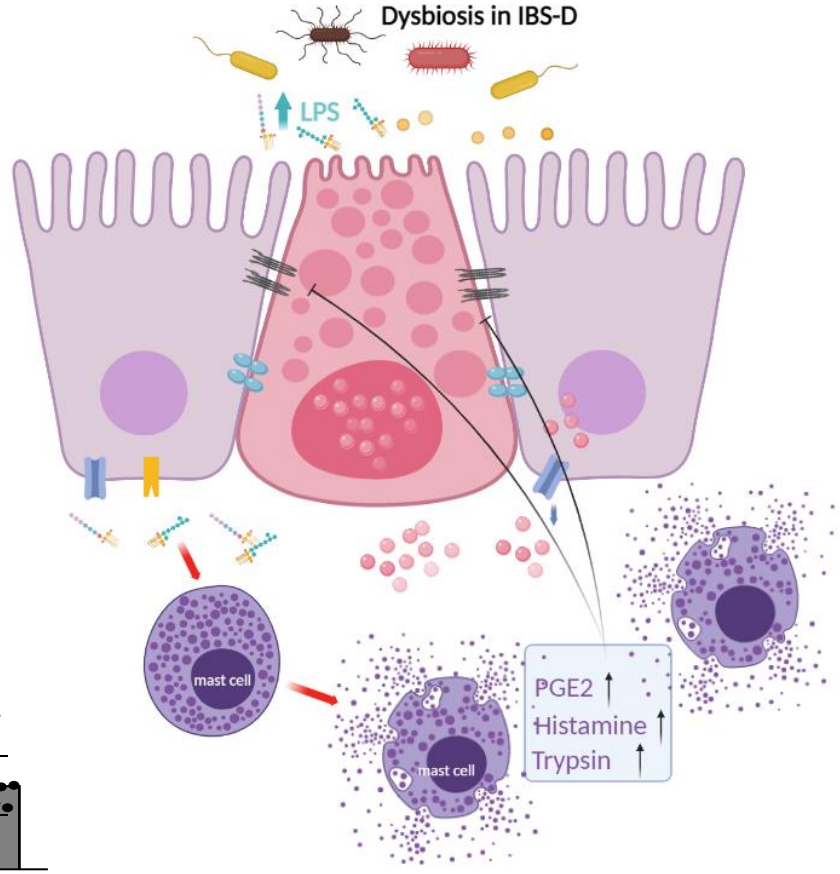
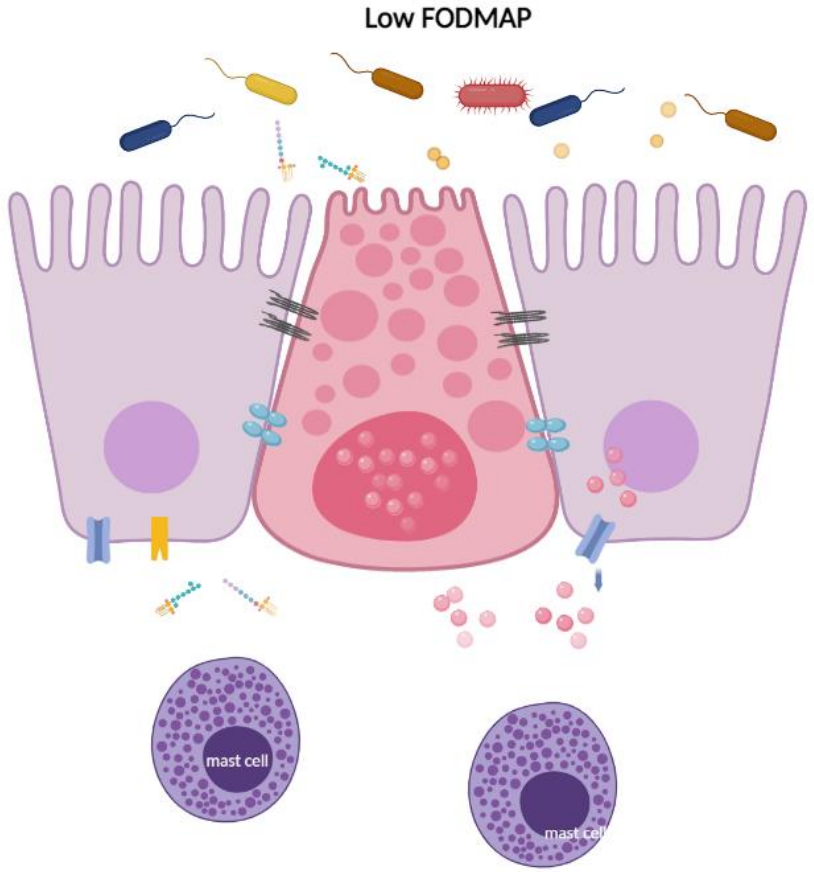
Fecal LPS-driven mast cell activation causes FODMAP-mediated barrier dysfunction











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Learning Objectives

- Why use it?
- When to use it (and when not to)
- How to use it?
- How does it work?
- Who should we use it in?

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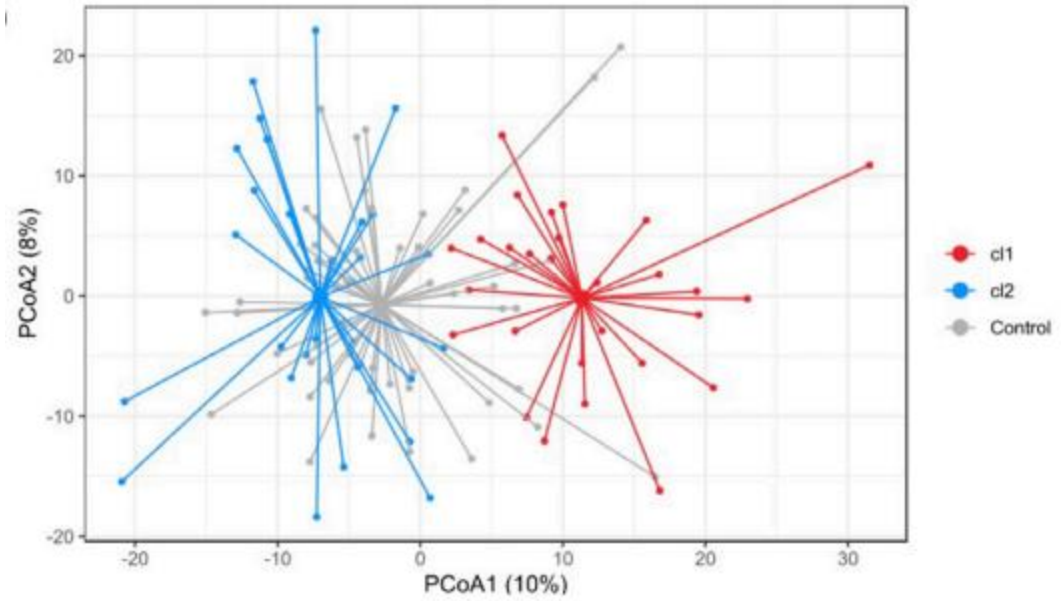
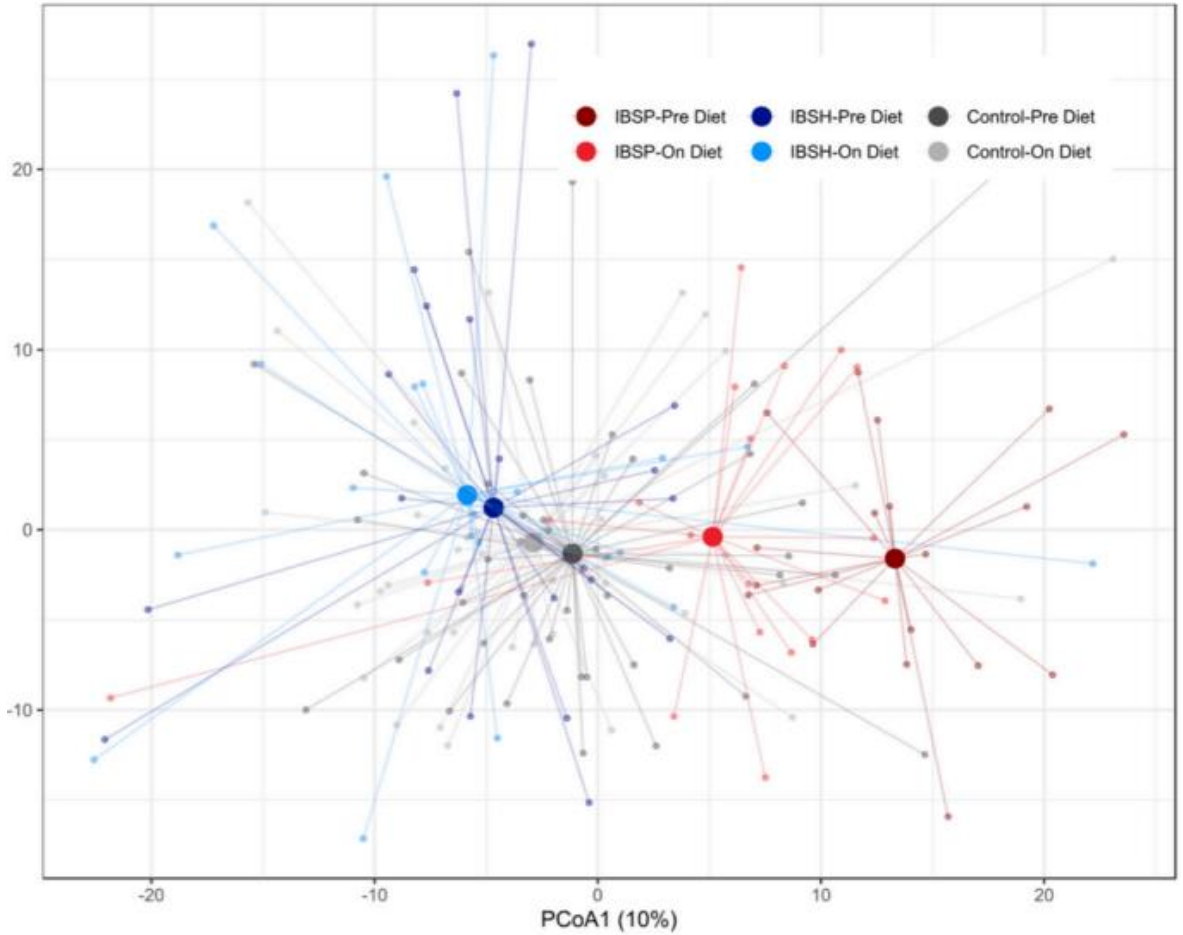
Two microbiota subtypes identified in irritable bowel syndrome with distinct responses to the low FODMAP diet





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Vervier K, et al. Gut 2021

No biomarkers are available, till then..

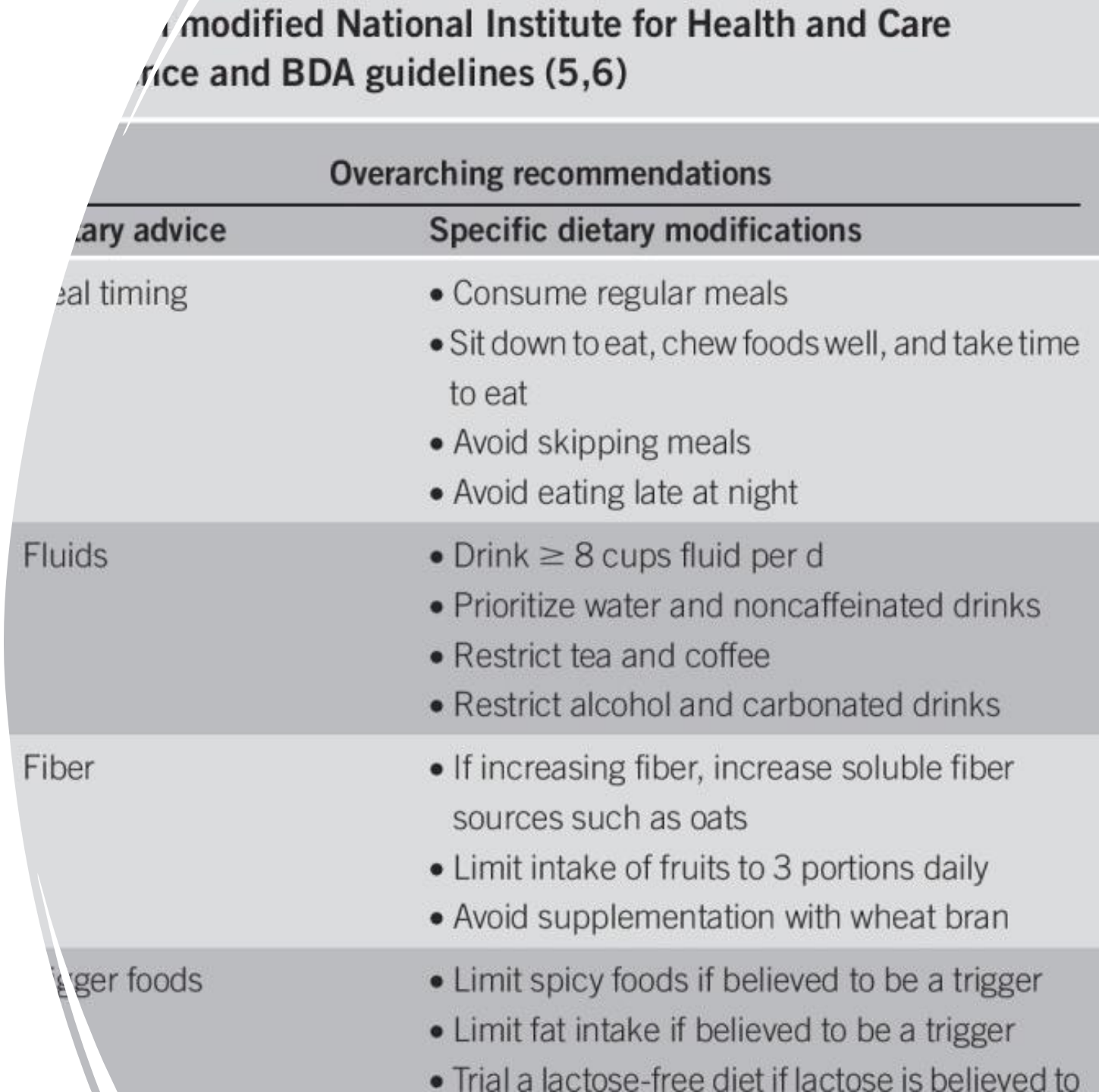
- Clinical judgment
  - Pain and bloating are predominant symptoms (all IBS subtypes)
  - Motivated to try dietary therapies
  - Some data that higher symptom severity more likely to respond
  - No red-flags

Learning Objectives

- List other dietary therapies in IBS (old and new).

NICE Diet

- No RCTs comparing this approach with habitual or sham dietary interventions.
- A recent meta-analysis found that the NICE guidelines were not superior to any of the alternative or control dietary interventions analyzed



modified National Institute for Health and Care
rice and BDA guidelines (5,6)

Overarching recommendations	
ary advice	Specific dietary modifications
eal timing	• Consume regular meals • Sit down to eat, chew foods well, and take time to eat • Avoid skipping meals • Avoid eating late at night
Fluids	• Drink ≥ 8 cups fluid per d • Prioritize water and noncaffeinated drinks • Restrict tea and coffee • Restrict alcohol and carbonated drinks
Fiber	• If increasing fiber, increase soluble fiber sources such as oats • Limit intake of fruits to 3 portions daily • Avoid supplementation with wheat bran
gger foods	• Limit spicy foods if believed to be a trigger • Limit fat intake if believed to be a trigger • Trial a lactose-free diet if lactose is believed to

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Why use NICE diet

- Ease of implementation
- Individual trials show up to 40% of patients respond
- Might be helpful for patients who don’t have a fixed meal routine or who needs “diet cleaning”
- More acceptable to patients

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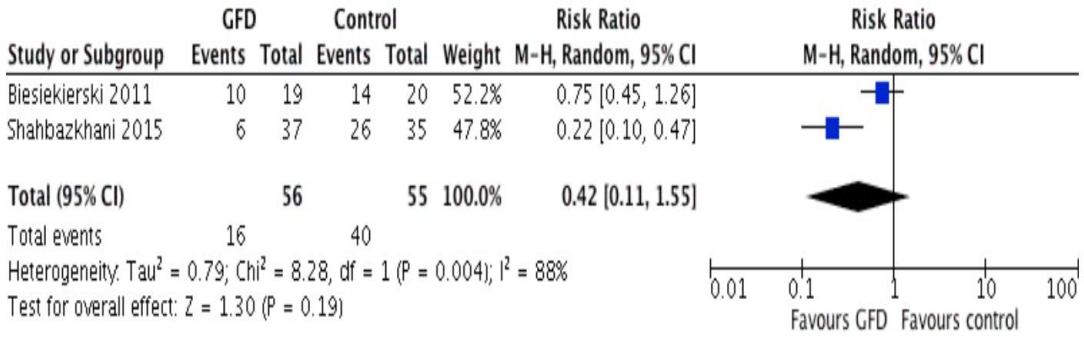
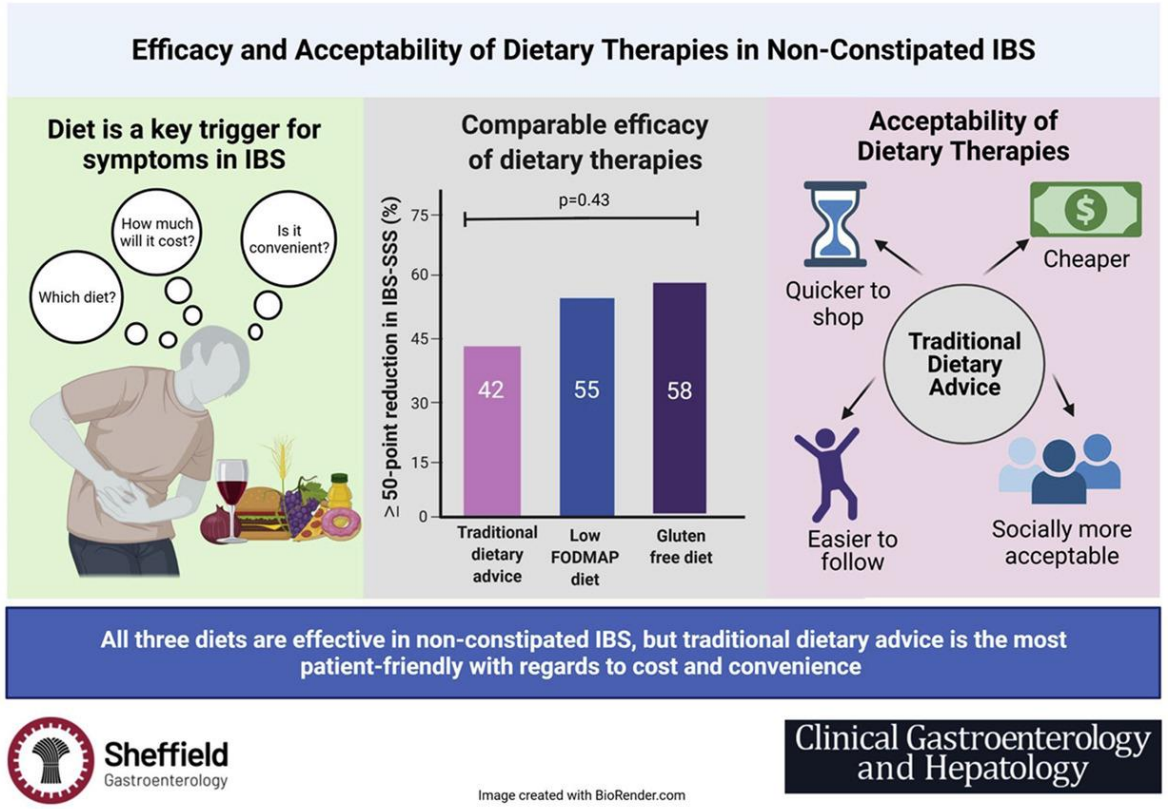
Rej et al, *CGH* 2022

Gluten–free diet in IBS



A GFD was associated with reduced global symptoms compared with a control diet (RR 0.42; 95% CI 0.11 to 1.55. I2 = 88%), although this was not statistically significant.



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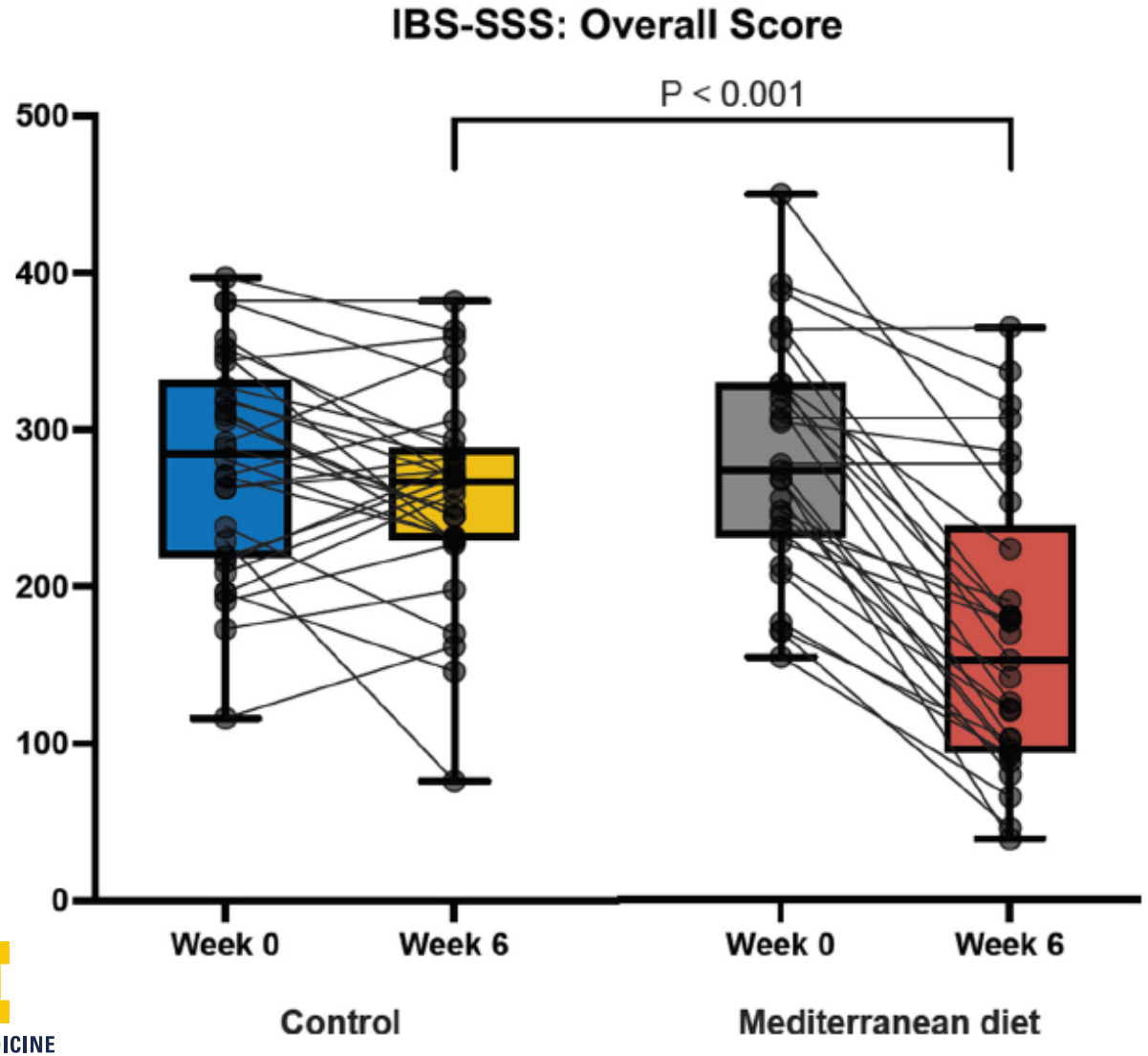
Mediterranean diet in IBS



- Significantly higher responders in the Med diet group compared to the habitual diet (83% vs. 37%)
- Significantly higher improvement in
  - Anxiety
  - Depression
  - IBS-specific QoL

Staudacher et al, APT, 2023

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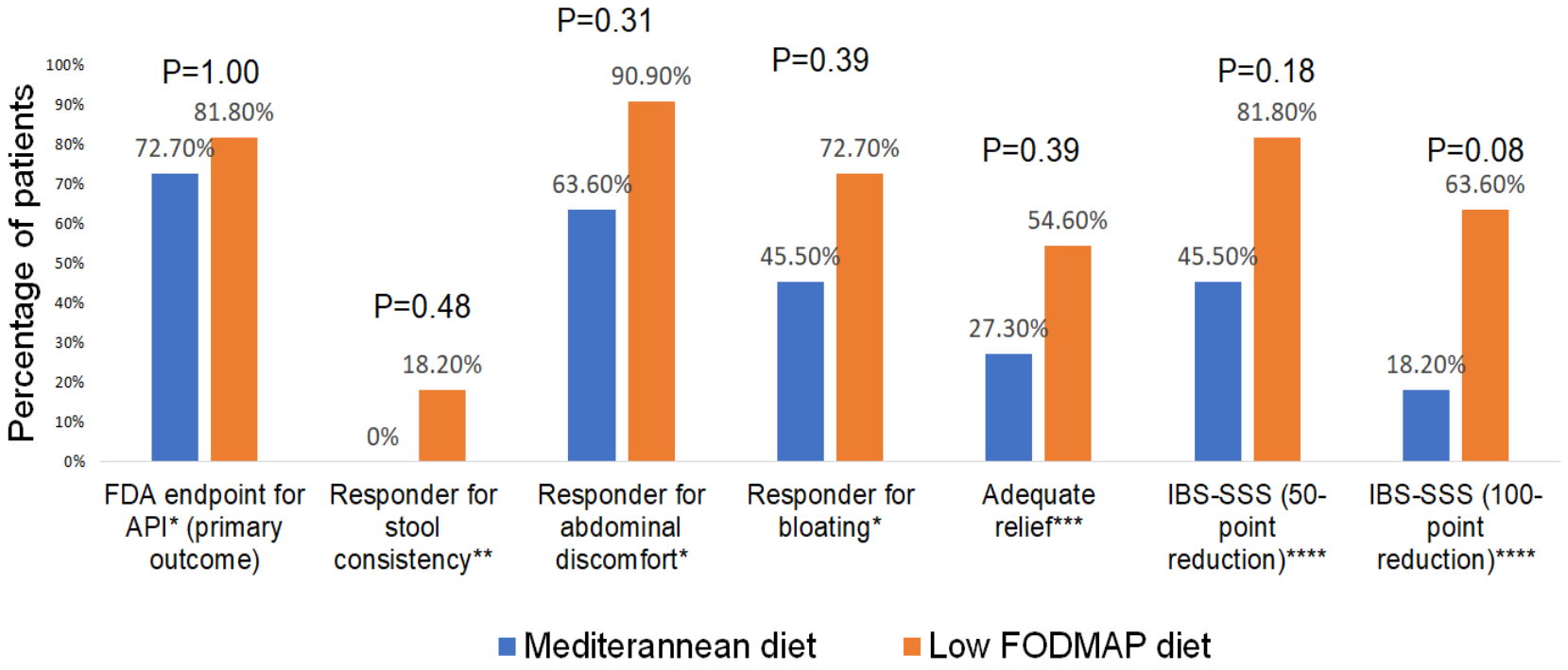
MD is feasible and effective in patients with IBS

- Pilot, feasibility trial comparing MD vs. traditional LFD (n=22).
- MD improves abdominal symptoms in IBS.
- LFD appears to be better than MD in improving global IBS symptoms.



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Singh et al, DDW 2024

IgG-based elimination diet in IBS

- IgG-based elimination diet offers a promising approach
- However, existing studies have significant limitations
  - Open-label
  - Lack of sham or control arms
  - Single center
  - Small sample size
  - No scientific rationale for selecting food for IgG assay
- Neither AGA nor ACG recommends use of IgG-based testing in IBS

Novel discriminatory p-value-based IgG assay

90 Commonly consumed foods (wheat, corn, beef, soy, nuts, etc.)

→ Testing IBS vs. non-IBS sera

50 foods with unadjusted p-values <0.05

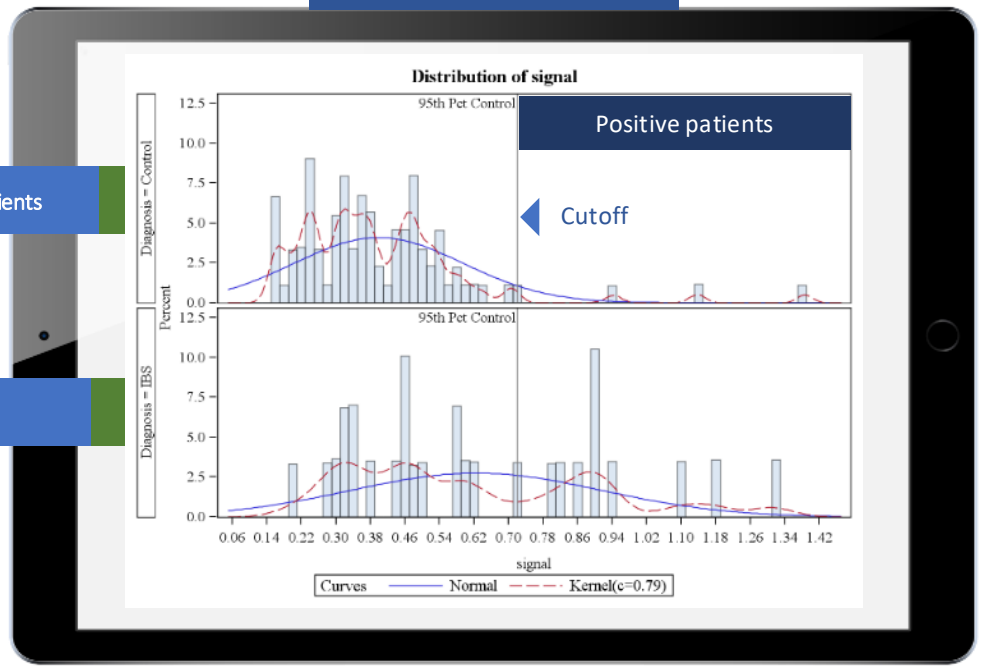
→ Statistical resampling and FDR adjustment

18 foods with FDR adjusted p-values <0.05

Food A

Non-IBS patients

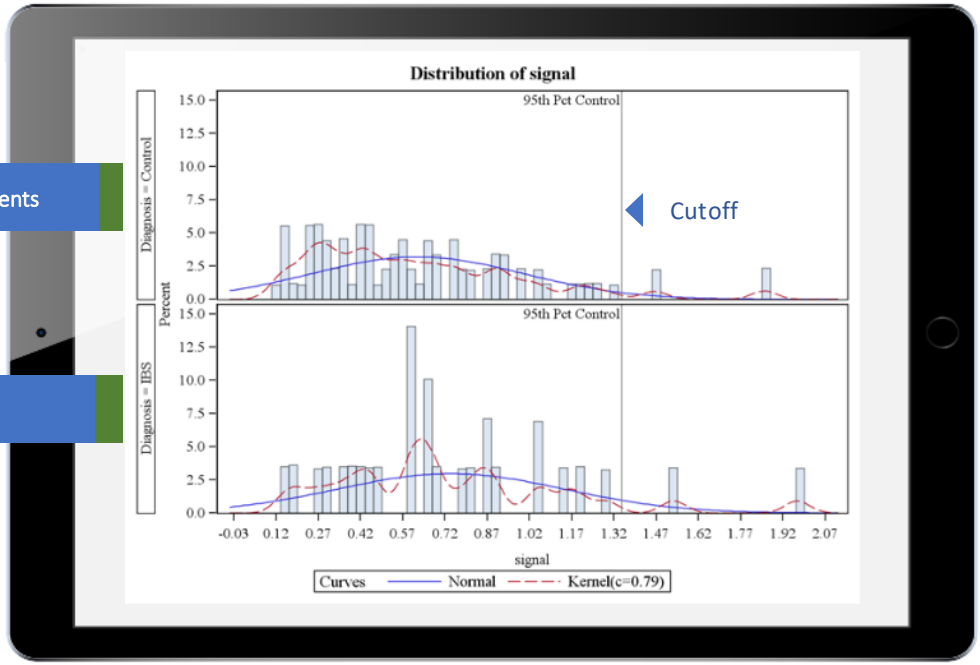
IBS patients



Food B

Non-IBS patients

IBS patients



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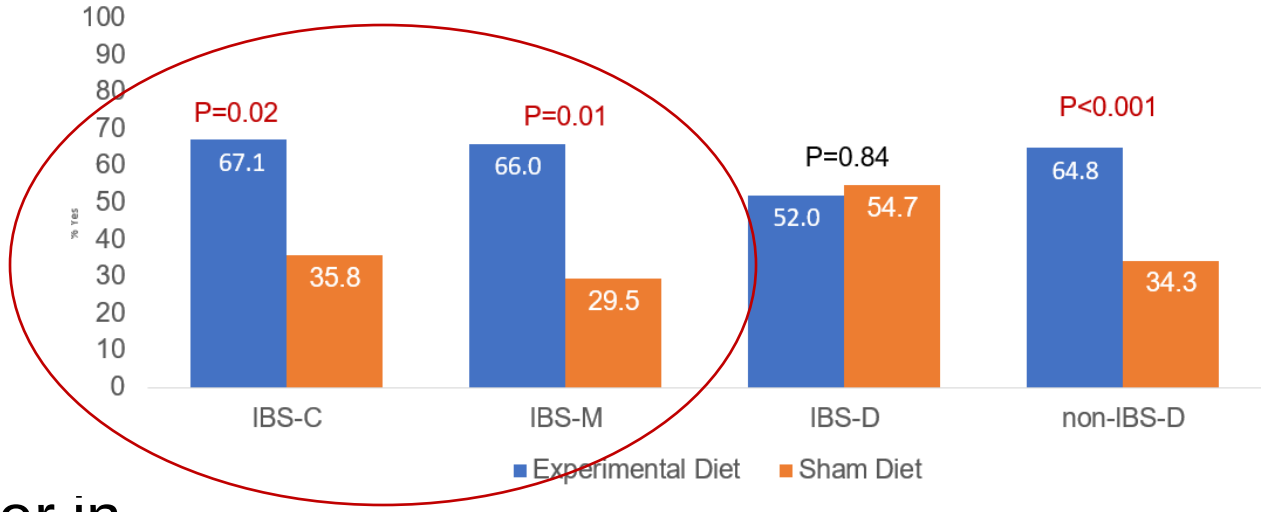
Primary endpoint (change in API)

Table 2: Clinical outcomes between experimental and sham diet groups

	Experimental Diet (n=118)	Sham Diet (n=105)	Δ	P value
Primary Outcome				
30% reduction in API	70 (59.6%)	44 (42.1%)	17.5%	0.02

- Multi-center (8 centers)
- 8-week
- Sham-controlled
- Double-blind RCT
- The primary endpoint was the FDA definition of abdominal pain responder in IBS.



Singh et al, Gastroenterology (Accepted) 2025

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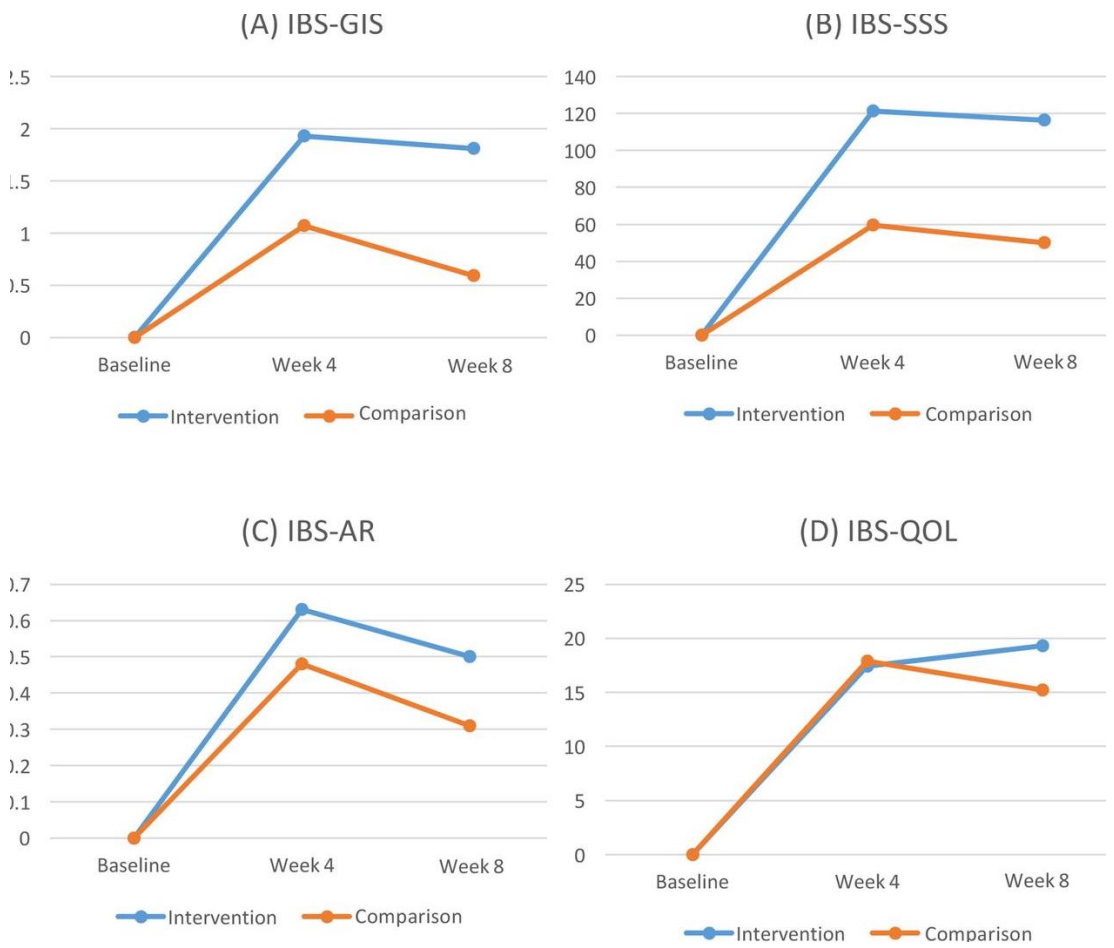
Leukocyte activation testing (LAT) in IBS

- Single center, double-blind, RCT
- N=58
- Primary outcome= IBS-GIS
- Elimination diet based on LAT better than a sham diet across multiple endpoints.
- ~200 food tested



Ali et al, BMJ Gastro 2017

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The use of fiber and functional foods in IBS.

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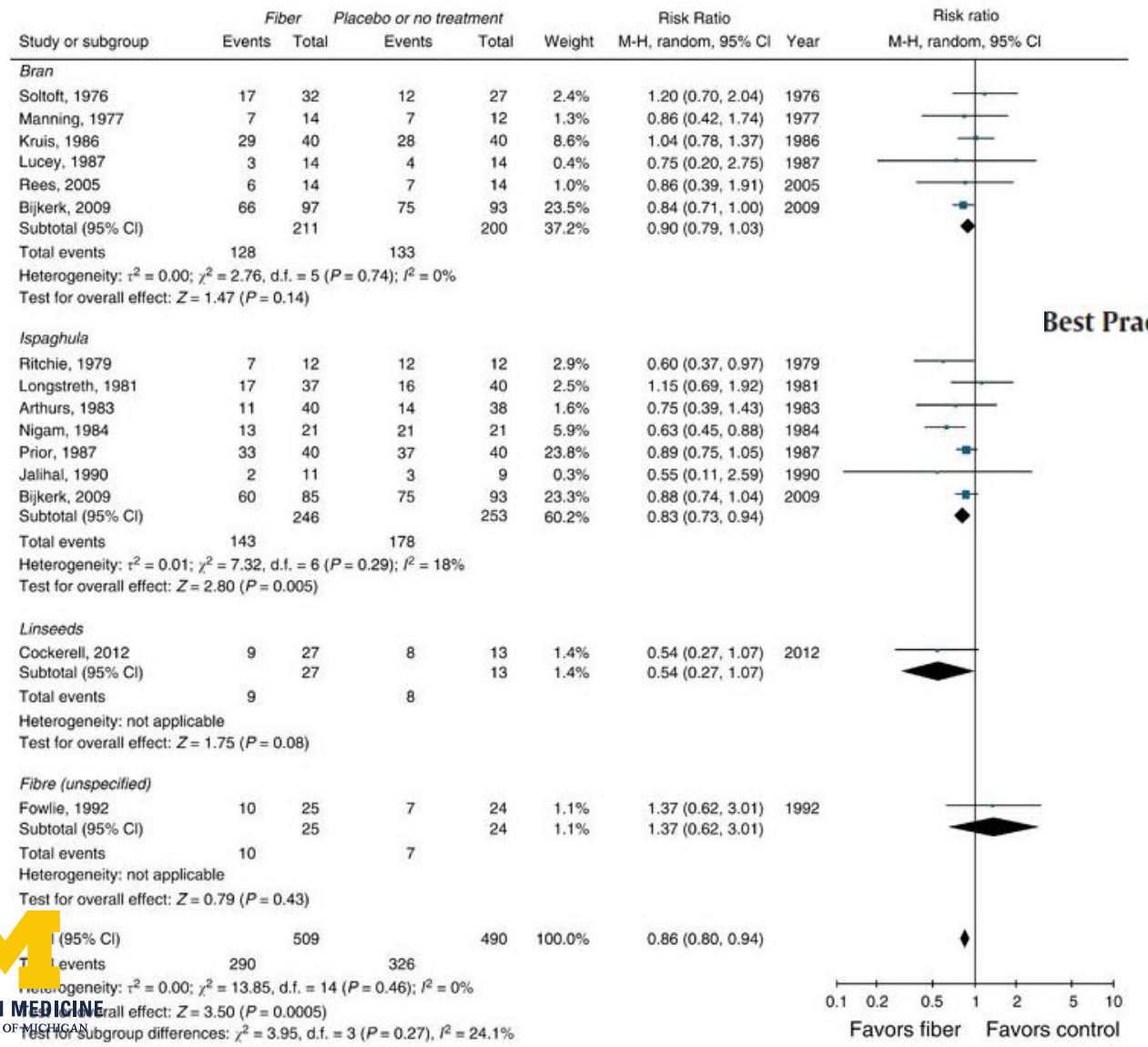
Fiber in IBS



Study or subgroup	Fiber Events	Fiber Total	Placebo or no treatment Events	Placebo or no treatment Total	Weight	Risk Ratio M-H, random, 95% CI	Year
Bran							
Soltoft, 1976	17	32	12	27	2.4%	1.20 (0.70, 2.04)	1976
Manning, 1977	7	14	7	12	1.3%	0.86 (0.42, 1.74)	1977
Kruis, 1986	29	40	28	40	8.6%	1.04 (0.78, 1.37)	1986
Lucey, 1987	3	14	4	14	0.4%	0.75 (0.20, 2.75)	1987
Rees, 2005	6	14	7	14	1.0%	0.86 (0.39, 1.91)	2005
Bijkerk, 2009	66	97	75	93	23.5%	0.84 (0.71, 1.00)	2009
Subtotal (95% CI)		211		200	37.2%	0.90 (0.79, 1.03)	
Total events	128		133				
Heterogeneity: $\tau^2 = 0.00$; $\chi^2 = 2.76$, d.f. = 5 ($P = 0.74$); $I^2 = 0\%$							
Test for overall effect: $Z = 1.47$ ($P = 0.14$)							
Ispaghula							
Ritchie, 1979	7	12	12	12	2.9%	0.60 (0.37, 0.97)	1979
Longstreth, 1981	17	37	16	40	2.5%	1.15 (0.69, 1.92)	1981
Arthurs, 1983	11	40	14	38	1.6%	0.75 (0.39, 1.43)	1983
Nigam, 1984	13	21	21	21	5.9%	0.63 (0.45, 0.88)	1984
Prior, 1987	33	40	37	40	23.8%	0.89 (0.75, 1.05)	1987
Jalihal, 1990	2	11	3	9	0.3%	0.55 (0.11, 2.59)	1990
Bijkerk, 2009	60	85	75	93	23.3%	0.88 (0.74, 1.04)	2009
Subtotal (95% CI)		246		253	60.2%	0.83 (0.73, 0.94)	
Total events	143		178				
Heterogeneity: $\tau^2 = 0.01$; $\chi^2 = 7.32$, d.f. = 6 ($P = 0.29$); $I^2 = 18\%$							
Test for overall effect: $Z = 2.80$ ($P = 0.005$)							
Linseeds							
Cockerell, 2012	9	27	8	13	1.4%	0.54 (0.27, 1.07)	2012
Subtotal (95% CI)		27		13	1.4%	0.54 (0.27, 1.07)	
Total events	9		8				
Heterogeneity: not applicable							
Test for overall effect: $Z = 1.75$ ($P = 0.08$)							
Fibre (unspecified)							
Fowlie, 1992	10	25	7	24	1.1%	1.37 (0.62, 3.01)	1992
Subtotal (95% CI)		25		24	1.1%	1.37 (0.62, 3.01)	
Total events	10		7				
Heterogeneity: not applicable							
Test for overall effect: $Z = 0.79$ ($P = 0.43$)							
[illegible] (95% CI)		509		490	100.0%	0.86 (0.80, 0.94)	
T[illegible] events	290		326				
[illegible]ogeneity: $\tau^2 = 0.00$; $\chi^2 = 13.85$, d.f. = 14 ($P = 0.46$); $I^2 = 0\%$							
[illegible] overall effect: $Z = 3.50$ ($P = 0.0005$)							
Test for subgroup differences: $\chi^2 = 3.95$, d.f. = 3 ($P = 0.27$), $I^2 = 24.1\%$							

We suggest that soluble, but not insoluble, fiber be used to treat global IBS symptoms.

Strong recommendation; moderate quality of evidence.

Best Practice Advice 5: Soluble fiber is efficacious in treating global symptoms of IBS.

ACG as well as AGA recommends the use of soluble IBS for global symptom improvement in IBS

Functional foods in IBS

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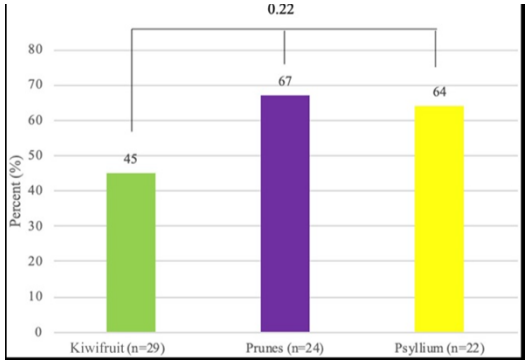
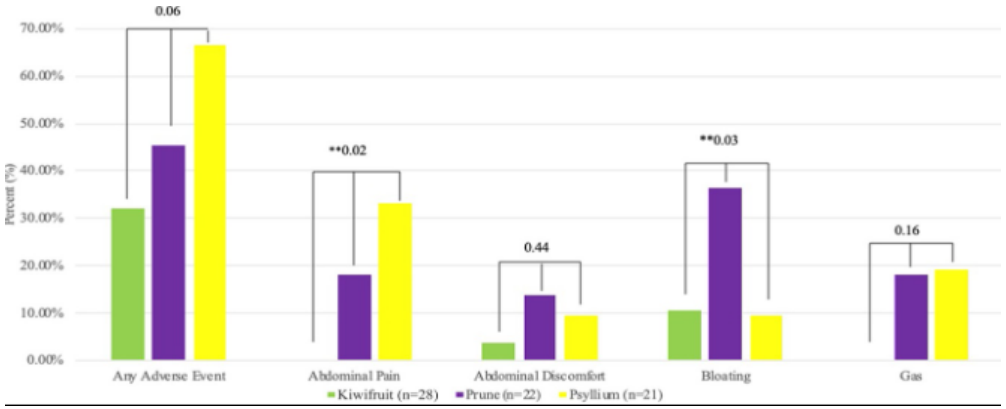
Kiwifruit in IBS-C and FC





Two peeled kiwifruits per day can significantly improve

- stool frequency
- stool consistency
- abdominal pain

- Might be slightly less effective than prunes or psyllium in improving stool consistency
- Appears to be better tolerated than prunes and psyllium

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SW Chey et al, AJG, 2021

Prunes in IBS-C and FC

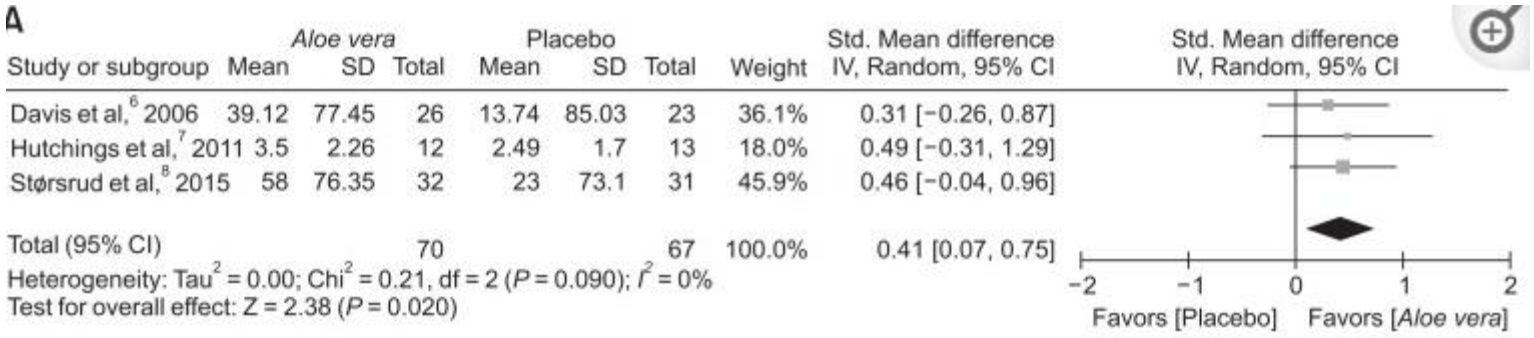
Table 1 | Effects of dried plums and psyllium on the number of complete bowel movements (CBMs) per week, spontaneous bowel movements (SBMs) and bowel movements (BMs) at baseline, and during treatment and at 6-week follow-up (mean ± S.E.M.)

	Baseline	Dried plums	Baseline	Psyllium	Follow-up	*P*-value (dried plums vs. psyllium)
CBMs/week	2.8 ± 0.3	3.6 ± 0.4	2.7 ± 0.2	2.9 ± 0.3	2.5 ± 0.3	0.001
SBMs/week	4.1 ± 0.4	6.5 ± 0.4	3.8 ± 0.4	5.4 ± 0.3	3.5 ± 0.4	0.04
BMs/week	4.4 ± 0.4	6.8 ± 0.5	4.1 ± 0.4	5.7 ± 0.6	4.4 ± 0.5	0.002

- In RCTs, prunes in doses of 80–120 g/d (100 g = 12 prunes) significantly increase stool frequency and stool weight to a greater degree than placebo or psyllium in patients with FC
- Might be effective for mild-moderate constipation
- Limited data in IBS-C

Attaluri et al, APT, 2011

Aloe vera in IBS-C and FC



A

Study or subgroup	Aloe vera Mean	SD	Total	Placebo Mean	SD	Total	Weight	Std. Mean difference IV, Random, 95% CI
Davis et al,[6] 2006	39.12	77.45	26	13.74	85.03	23	36.1%	0.31 [−0.26, 0.87]
Hutchings et al,[7] 2011	3.5	2.26	12	2.49	1.7	13	18.0%	0.49 [−0.31, 1.29]
Størsrud et al,[8] 2015	58	76.35	32	23	73.1	31	45.9%	0.46 [−0.04, 0.96]
Total (95% CI)			70			67	100.0%	0.41 [0.07, 0.75]

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.21$, df = 2 ($P = 0.090$); $I^2 = 0\%$
Test for overall effect: Z = 2.38 ($P = 0.020$)

Barbaloin, one of the major components in AV, plays a critical role as a laxative

Small studies, total sample size including 3 studies around 150

Improves abdominal pain and bowel satisfaction.

The dose studied is between 100-200 ml daily.

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Summary of probiotics and prebiotics

- Recent guidelines by both the American College of Gastroenterology and the American Gastrointestinal Association either “recommend against” or make “no recommendation” for use of probiotics for treatment of IBS.
- Very limited data on prebiotics in IBS and unclear if it benefits our patients

Summary

- LFD is the most evidence-based diet in IBS
- Abdominal pain and bloating are the symptoms most likely to improve with LFD
- Can be used in all IBS subtypes
- Could be considered as first-line therapy in IBS
- Use with caution and screen for ARFID/eating disorders

Summary

- Simplistic view of LFD working via reduction in osmotic effect alone is likely not true
- It directly targets IBS pathophysiology by improving

❑Mast cell recruitment and activation

❑Barrier dysfunction

❑Visceral hypersensitivity

❑Fecal LPS appears to be a key mediator

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Summary

- A FODMAP-simple diet offers a promising alternative ‘step-up’ approach to implementing LFD
- Individualized approach to an elimination diet (e.g. IgG-based, LAT) or alternative approach (e.g. Mediterranean diet) is possible.
- For all these approaches, larger, adequately powered studies are needed

Summary

- Soluble fiber should be used/considered for global IBS management
- Functional foods can also be used for the management of GI symptoms in IBS (more data is needed)
- Available data on dietary supplements, probiotics, and digestive enzymes (e.g. amylase, etc.) does not support their use in all IBS patients.

Thank you

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