AN IFFGD EDUCATION PROGRAM

BECAUSE DIGESTIVE HEALTH MATTERS

Live Stream Q+A – Sunday, 10.11.2020

University of Michigan: Diet, Nutrition and Digestive Health

Q: I just got out of the hospital with diverticulitis. Any tips and/or tricks to avoid that nightmare again?

A: They used to think that avoiding nuts, seeds, and popcorn would prevent diverticulitis, but we actually know now that diet does not matter too much in the long run. The key going forward will be to keep your bowel movements soft and regular, in particular, you want to avoid constipation. A diet of high fiber (from food or supplementary fiber) is useful in this situation.

Q: Fiber is not working for me. Does this mean I don't have IBS?

A: Fiber is a time-honored treatment for IBS, but it is not always straightforward. There are many types of fiber and individuals can do better or worse with one or the other. So, trying different types of fiber can be helpful. In general, soluble fiber is better tolerated than insoluble fiber.

Q: What is the best way to find a dietitian?

A: The IFFGD website has a list of registered dietitians with an interest in GI diseases. Click here to find one in your area.

Q: During the cooking demonstration, she used Pacific Broth/Stock and it has garlic, onion, tomatoes, lots of things GI patients cannot have. Is there an alternative?

A: You can make your own broth but can be labor intensive, so another option is Fody Foods, who makes a great low FODMAP powdered broth.

Q: Can celery root be found year-round? Is there something I can use in place of celery root?

A: Yes, celery root can be found year-round, although its peak season is September to April. A russet potato can be used in place of celery root.

Q: Can I use farro in place of quinoa? If not, are there other grains I can use?

A: You can but unfortunately farro is not FODMAP friendly or gluten free. Another substitution would be wild rice in place of the quinoa to make it FODMAP friendly. Grains that are FODMAP friendly: corn, potato, rice, oats and quinoa.

Q: Congenital sucrase-isomaltase deficiency (CSID), is this common?

A: The short answer is no; usually it is a condition that is diagnosed in infants and toddlers as they are starting to introduce food into their diet transitioning from breast milk or formula. We are beginning to understand there are less severe forms of CSID that won't be picked up until patients reach adulthood and are still having symptoms or they may have a mild case that is coupled with something else. A lot of research is being done to determine what the true prevalence of CSID is in the adult population.

Q: I am not clear on digestive enzymes. Are these things that our body creates? Or things that can be taken as an additive, or both? Are they useful?

A: The pancreas makes enzymes to digest and break down macronutrients. Sometimes we are deficient in these enzymes like in conditions such as pancreatic insufficiency. There are over the counter and prescription strength enzymes available.

Q: I am very familiar with GERD and reflux. My daughter has GERD. She also has Parkinson's disease. I think that she should talk to her GI doctor to determine if they impact each other but she disagrees. Should she mention this?

A: Absolutely! Your provider will ask you about your symptoms including your medical history. We ask this because a lot of disease states can overlap or cause GI symptoms. Parkinson's disease is primarily a neurologic and motor disease but can have a profound effect on gut motility, so it is really important that your provider be aware of this.

Q: Any comments on long-term use of proton-pump inhibitors (PPIs)? Implication for possible increased risk of Small intestinal bacterial overgrowth (SIBO) and Irritable Bowel Syndrome (IBS)?

A: That is a question that is asked a lot. There is a lot of popular press about the long-term use of PPIs and people have cited dementia, kidney disease, and osteoporosis and in general the association between these are very weak. If you are getting a benefit from your PPI, it is okay to keep taking it at the lowest dose that is helpful. If you don't think it's helping you, many times it can be okay to discontinue it altogether.

In terms of the side effects, one of them I hear a lot is diarrhea and bloating. So in some people it can make their IBS a little worse. The relationship with PPI and SIBO is an interesting one; there have been a few studies that suggest there may be an increased risk but there are also a few studies that do not demonstrate any increased risk of SIBO. So with every medication we take we see if it is really needed, and if so, how long is it needed because there may be a time when it is safe to come off this medication.

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Q: What is the nocebo effect mentioned during Dr. Brandler's talk?

A: Most people have heard of a placebo effect, which is when you go into a situation with a preconceived notion that something is going to make you feel better and because you have that conditioning you actually do end up feeling better whether it is from the medication/treatment or from your expectation.

The nocebo effect is essentially the opposite. So if I go into a situation thinking I am going to get a side effect from a medication, I'm going to be more likely to get that side effect. Or if I go into a situation where I'm fearful, that a particular food is going to make me feel badly, there is a much higher chance that I will actually feel worse from that food.

These both can really effect how a patient is feeling with or without being exposed to a certain kind of treatment/medication or food.

Q: I take pain meds for my back. I struggle with constipation and it seems worse after starting this medication. My friend said that is common. Should I talk to my doctor to see if they can help?

A: Not all pain medications are associated with constipation, but opioids are definitely associated with a diffuse slowing of the GI tract in general. The constipating effect of opioids are pretty immediate and do not necessarily improve with time. Opioids decrease or slow down the transit time in the gut and they also decrease rectal sensitivity and make pelvic floor dyssynergia worse.

We generally treat opioid induced constipation pretty similarly to how we treat other kinds of constipation. There are available medications specifically for opioid induced constipation (OIC) that block the effect of opiates in the GI tract while maintaining their effects on pain.