

Dietitian Connection Webinar: Dietary management of IBS – the low FODMAP diet & other adjunct therapies

Presented by Shirley Webber and Dr Jane Varney

Q. When doing the challenges, does the patient have to try the both of the foods or only one food from the list?

A. We suggest you start by choosing one rich in one FODMAP subgroup while keeping the background diet low in FODMAPs. Once tolerance to that FODMAP subgroup has been determined, the patient could try other foods rich only in that FODMAP subgroup, e.g. mango. This approach is recommended to provide the clearest idea re which FODMAPs trigger symptoms and which do not.

Q. I work in a clinic with a hypnotherapist - would they need additional training for gut directed hypnotherapy? Or would they have those skills as a generalist?

A. The general hypnotherapy course unfortunately does not cover gut-directed training and you will have to speak to the hypnotherapist to see what training they have had in gut-directed therapy if any. A hypnotherapist with general hypnotherapy training would not have the expertise to deal with gut issues. We would suggest that you look for a hypnotherapist in close proximity who has gut-directed training. There are also apps that are readily available on the app store if location to a specialised therapist is difficult. Generally, face-to-face consultations are better. We also suggest where recommending an app, look at the description of the app and what it will be providing to ensure it delivers what your patients need.

Q. Can you please comment on - a link between female hormones/contraceptives and IBS, and recommended probiotic strains?

A. We have not extensively looked into the link between hormones / contraceptives and IBS. We do however know that there is a link between symptoms and worsening symptoms during particular time in the menstrual cycle.

<https://www.monashfodmap.com/blog/ibs-and-that-time-of-month/>

<https://www.monashfodmap.com/blog/one-ladies-yes-were-talking-time-monthagain-part-2/>

As for recommending specific probiotic strains there is still insufficient evidence to recommend a specific probiotic strain for IBS. There is some evidence that probiotics may partially reduce symptoms of bloating and flatulence. Large multi-centred studies are needed to further strengthen current evidence on probiotics.

Probiotic type	Active probiotic strain	Generic product
Lactobacillus	L. casei shirota	Improvement in flatulence abdominal discomfort
	L. rhamnosus GG	
	L. plantarum 299V	Reduced flatulence Pain relief
Bifidobacteria	B. animalis DN173-010	Bloating reduced
	B. animalis lactis HN10	
Saccharomyces	S. Boulardii	Improved quality of life No significant symptom relief
Multi-species probiotics	Combination of 8 lactobacillus, bifidobacteria & streptococcus strains	Bloating was reduced In the long term only flatulence improved Abdominal pain and distension improved
	L. acidophilus NCFM & B. lactis Bi-07	Bloating reduced significantly

Q. With the A1/A2 studies, did they control for other dietary changes that could potentially happen?

A. For the studies discussed in the webinar the dietary changes were:

He et al – Dairy free wash out and during trial (other than intervention milk)

Jianqin et al – Dairy free wash and during trial (other than intervention milk)

Ho et al – Dairy free wash out and during trial (other than intervention milk)

Boutrou – not described

As for the study that we are conducting at Monash we are controlling for dietary changes, asking IBS participants to follow a dairy free diet and remain low FODMAP throughout the

intervention periods. For healthy participants however they are only asked to remain dairy free for the intervention periods.

Q. What is the protein in protein powder - combination of A2 and A1 usually (might not be a relevant question), people look for lactose free but maybe the protein is important to IBS people too?

A. The protein in protein powders depend on the protein powder and its predominant protein chosen.

Sports protein powders are mostly whey protein based and in these cases there are no casein and therefore no beta-casein in these products. There are however, some casein protein powders on the market and in this case yes it may be necessary to think about the combination of A1 and A2 beta-casein proteins that is present in that powder and the effects that this may have on your athlete client. It is likely that the ratio of A1 and A2 beta-casein would be similar to that which you would see in conventional milk that does not specify that it is A2-only-beta-casein. If your patient seems to react to the A1 beta-casein then you may want to look at recommending a whey protein or plant based protein.

Enteral nutrition supplements typically contain whey and casein and will be produced from conventional milk, therefore will contain A1 and A2 types of beta-casein. There are currently no A2 beta-casein only enteral nutrition products currently commercially available. Lactose +/- depending on the product, also need to consider FODMAP of other ingredients.

Milk powders are mostly made from conventional milk and therefore contains both the A1 and A2 types of beta-casein, plus lactose, as per fresh milk. a2 Milk™ powder is the only milk powder made from A2 beta-casein only milk, this also contain lactose, as per fresh milk.

Q. Are there particular probiotic supplements MONASH recommend people trial?

A. We do not as a rule recommend any particular brand of probiotics. If a patient is keen to try probiotics then there is no harm in trialling them. It is important to note that not all probiotics are the same and if a patient finds that one strain doesn't work for them then they may need to trial a different strain of probiotic or even a different brand to find something that works for them. There is still more research needed in this area to learn more about the effects of each strain of probiotic on the various symptoms.

Q. What are the Australian guidelines for IBS?

A. There are no set Australian guidelines for IBS. There are international criteria for the diagnosis of IBS called the Rome IV criteria.

These highlight the symptoms used to diagnose IBS. IBS is considered to be a functional gut disorder with the definition being;

Functional gut disorders are disorders of the gut-brain interaction. It is a group of disorders

classified by GI symptoms related to any combination of the following: motility disturbance, visceral hypersensitivity, altered mucosal and immune function, altered gut microbiota, and altered central nervous system processing.

This means that changes in different body processing can lead to functional GI disorders eg:

- Motility disturbance
- Visceral hypersensitivity
- Altered mucosal and immune function
- Altered gut microbiota
- Altered central nervous system processing

This takes into account that functional GI disorders require a biopsychosocial approach taking into consideration:

- Early life influences, genetics, culture, environment
- Psychosocial factors, stress, personality, psychological state, coping, social support
- Physiology, motility, sensation, immune function, microflora, food and diet.

Diagnosis of IBS – criteria:

Recurrent abdominal pain on average at least 1 day per week in the last 3 months, associated with ≥ 2 of the following:

Related to defecation

Associated with a change in stool frequency

Associated with a change in stool form (appearance)

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

Q. Do you have any other hints if client living with IBS and mainly abdominal pain and no improvement on low FODMAP diet?

A. If the low FODMAP diet has not worked for a patient with IBS and you have confirmed that they complied with the dietary restrictions, encourage them to reintroduce FODMAPs and consider other therapies (e.g. gut directed hypnotherapy).

If you do not think hypnotherapy will work for your patient then do another thorough investigation into their diet to see if there are any specific trigger foods for their symptoms eg. fat, capsaicin, caffeine etc. The patient may need to go back to a gastroenterologist to see if there are any other underlying health conditions causing their symptoms eg. Coeliac disease if they haven't been investigated for the condition before or other inflammatory conditions.

Q. How do you distinguish from an upset stomach and IBS?

A. A diagnosis of IBS can only be made where symptoms have occurred on 1 day per week

lasting for 3 months and onset at least 6 months before diagnosis. In the case of an upset stomach symptoms should have resolved in that period of time.

Q. Is the Monash Uni Low FODMAP Diet Guide for professionals and/or consumers?

A. Both. The Monash University diet guide booklet is for mainly for those who do not have a smart phone or prefer to have a paper copy of the app. Many dietitians prefer to use the guide in their practice to show their patients a quick reference of the types of foods that can be consumed on a low FODMAP diet. The booklet however does not have the same extensive information on all the foods that have been tested and is not as regularly updated as the Monash University low FODMAP diet app and therefore the app is our best source of up-to-date information.

Q. How much is the Monash low FODMAP course?

A. The course is AUD \$ 829.95 (including GST). With a course completion due in 6 months from the time of registration and payment. You can find out more at:

<https://www.monashfodmap.com/i-am-a-health-professional/online-fodmap-training/>

Q. Can you comment on SIBO or parasites as an underlying cause of IBS?

A. There are problems with the definition and diagnosis of SIBO and in Australia (unlike in the USA) it is not a major focus of therapy.

See our blog on this at: <https://www.monashfodmap.com/blog/whats-go-with-sibo/>

Q. When challenging, is it just the two foods for 3 days and cease, then try another 2 i.e. ceasing each time rather than adding a second 2 to the first 2 and so on? (E.g. is it one pair at a time?)

A. With the re-challenge we suggest only using one food to re-challenge each of the FODMAPs and keeping the background diet low in FODMAPs. Once having completed the challenges for each FODMAP you may want to choose a single food that contains two FODMAPs to see how this is tolerated in combination. It is important to keep the background diet low FODMAP to ensure that there are no other potential triggers. Having said that. If a patient does not have any issues with eg. Lactose then there is no reason to avoid lactose during the re-challenge phase.

Q. In a recent Dietitian Connection lecture by Dr McMillan, there was mention of inflammation in IBS patients (she was working with gastros at the time). What is Monash's thoughts on inflammation in IBS?

A. It is possible that there may be some low-grade inflammation in IBS contributing to the symptoms a patient may experience. Where the inflammation is severe, this is where we would consider other gastrointestinal issues such as IBD, Crohn's disease or Ulcerative Colitis.

Q. What if a client has identified a low FODMAP food causing symptoms? What do you do in that instance?

A. Food components other than FODMAPs may trigger gastrointestinal symptoms, although evidence for diets that reduce/remove these components is not as strong as for the low FODMAP diet. Other possible dietary triggers include, fat, caffeine, fibres (too much or too little) and alcohol (among others). We would ask that person to just exclude that offending food and monitor symptoms. If symptoms improve they may want to consider what components in that food may be triggering symptoms and trial a reduction in the intake of that component. It is advisable that the patient only try one dietary strategy at a time so they can determine what is having an effect on symptoms.

Q. There is a gut directed hypnotherapy app - Happy Inside. Have you heard of it? Any thoughts on the App?

A. No we are not familiar with that particular hypnotherapy app. There are a number of apps available and we recommend looking at who the therapist is behind the apps to make sure that they have been developed or had the input of a person in the field with a good knowledge of gastrointestinal issues particularly IBS.