

---

The next topic where I'd like to go back to the community setting and the sufferers in the community setting and ask you, Pali, what sort of things can the sufferer do to reduce their symptoms? And one of them might be understanding the disease and researching it to the extent that Eamonn has just suggested some patients are now doing or sufferers are now doing.

I'm quite convinced, Richard, that the secret to being well or being better or being able to cope with irritable bowel syndrome is a greater awareness of it. And this means learning much more about it; looking at appropriate websites, being properly informed of the various types of symptoms and what one can do about it.

From the practical viewpoint, after having gathered as much knowledge as possible many of the self-help items that can be used are commonly available: relaxation exercises, the ability to alter one's lifestyle to make it perhaps somewhat less stressful. We recognize a link between stress and symptoms. Perhaps modifications in terms of diet. And also increased exercise, a healthier approach, as well as, of course, a dialogue with the doctor in terms of what therapies or medications might be useful for the most troublesome symptoms.

Now Pali has mentioned diet there, which is a big talking point in the health spectrum of irritable bowel syndrome, Anton. Give us the sort of update as to what we should be thinking about, and particularly the sufferers should pay attention to.

The first thing I'd say is obviously we need to be receptive to what the patient's experience is. Some patients feel that their diet is blameless and actually there's no relationship between their symptoms and their diet, but as you say, a majority often have a sense that there must be. And I think the first thing is that it's often the context of the meal and the style of eating which is probably more important than actually the nature of what the foodstuff is that's being put into our mouth. And therefore, trying to understand, you know, when patients have dietary symptoms, is it a relation to diet at work, when they are eating on the hoof, or is it mostly a weekday phenomenon?

Skipping breakfast

Yes, the pressures of modern life put upon us with school runs and work life. So there's that aspect of things.

---

---

Within that, however, we must also - once you've talked about the context of food and trying to get the balance that Pali described - we also have to think about the particular foodstuffs, because certain patients are very clear in their description that, "Every time I eat tomatoes or mushrooms" or certain things which are for them individual, they will say that they are very clear that these things trigger symptoms. And we try to make a point that sometimes people are intolerant of certain foods, and that's quite distinct from talking about being allergic to a food. I think that's a very important point, because people can go down sort of false paths where they're looking for allergies, and allergies in the gut do exist, of course we know. People eating things or people exposed to things, we get the typical sort of hives type reaction, and that's a very characteristic and unpleasant thing. But that's quite distinct from the gut symptoms that patients are describing here. Patients will get this

Probably more common in children

That's exactly right. So I think that kind of true allergy is something which we, again, we will spend time to tell patients it is not what's happening, but it's more to do with how well your gut and you tolerate a certain foodstuff that maybe is causing trouble.

And one of the real culprits we see in both children and adults is this issue around milk products and this milk sugar called lactose. And in some individuals there may be an issue where they don't-

have the right balance of enzymes in their gut, which helps them break down this milk sugar, and therefore they can get rumbling tummies and sometimes loose stools and tummy pains. And that is an issue for some people. And again, patients will often have picked this up themselves and they've had made little adjustments to their life, and we can sometimes sort of seize upon that as a way to try to help the patient develop some part of the self-help.

And I think it's interesting that we're all sort of saying the same thing. We may see patients in slightly different context, but actually it's about building up that common message from both primary and secondary care so that it isn't that, "Well, this doctor said this and now you're saying this about food." I think that has been a danger historically; some patients will have experienced certain doctors who are very enthusiastic for certain approaches. And I think that's one of the things that's actually held back IBS patients, and I hope that this commonality of approach is something that is useful going forward.

---

---

What about gluten, Eamonn? There is this association with a slightly higher rate of actual celiac disease, but it seems to extend to patients who do not have celiac disease. Gluten still seems in some patients to present a problem.

Well, I think there are two important points here. The first is that celiac disease has changed, and Richard, you and I will remember a long time ago, when we were medical students, a celiac patient was emaciated and had terrible diarrhea and was malabsorbing lots of vitamins, etc. We don't see those patients anymore. Nowadays the celiac patient presents with kind of IBS-type symptoms. So that's the first point to make, of the diagnostic side is that it's important in countries where the incidence of celiac disease is high, and that applies to most European countries, we should be checking for celiac disease.

So once we got that out of the way, you're absolutely correct, there seem to be patients who do not have celiac disease, but who still tell us that they have problem with gluten. And up until recently I have to admit I thought they were taking nonsense. But they're not. And there's now been a number of studies, very good studies, which have shown that there appears to be an intolerance – and I use the word very carefully, as Anton was pointed out – I use the word “intolerance” to gluten, which can be helped by going on a gluten-free diet. And similar research has also shown, again, very like Anton said, that there is an intolerance to some other sugars, like fructose and sorbitol and so-called FODMAPs among patients with irritable bowel syndrome, which can be helped by dietary interventions.

But I would emphasize again and again a point that Anton made, is the difference between allergy and intolerance.

Because unfortunately, there are a lot of people out there offering allergy tests, which are expensive, which yield useless information as far as I'm concerned on irritable bowel syndrome, and I believe that in irritable bowel syndrome in general there's really no place for allergy testing. But there is a great place for a detailed evaluation of the diet and possible dietary interventions.

And I think another caution about the allergy testing is that it may lead to patients or sufferers excluding something from their diet which they actually don't need to do. Would you like to say something about exclusion diets, Anton?

---

---

So I think this is quite a tricky area, because again, patients often have a perception of certain things which are very much a nuisance and will therefore exclude that. And again, as I was saying earlier on, this was a cumulative set of symptoms over years; people will gradually exclude this and then add this exclusion and add that exclusion and actually then what you can sometimes end up with is the occasional patient who's taking a very restricted diet and then feeling the need to supplement that with, you know, little capsules of this and that from the supermarkets. And I think that's often erroneous because it's an understandable danger that patients face when they haven't had good advice from specialists who haven't had much to say on the subject, or if they have had something to say have often been wrong. And I think therefore we have to almost let the patients gradually come back to the fold almost and say, "Look, let's try and reintroduce it and find out what your symptoms are; unfortunately, it's bad, but at least you're eating in a more sensible way."

And one of the particular things I guess we need to mention in this situation is this issue around fiber.

Yes, I was going to ask you about that, because clearly some get benefit, others don't. How would you suggest to our audience today that a sufferer of these symptoms might address the fiber issue?

This has been a thorny issue for sort of 70, 80-odd years we've had this notion of fiber being a very important thing. And certainly for a lot of patients who have a sluggish bowel where the stools are sort of poorly formed and the like, augmenting dietary fiber can be a way of doing it. The problems are that it isn't absolutely clear to most patients, and in fact lots of doctors, how best to do that. The first thing is that the fiber comes in, broadly speaking, two forms. There's the so-called soluble and insoluble forms. And in general terms soluble fiber refers to the fruit and vegetable fibers, whereas insoluble fiber mostly refers to those cereal-type fibers. And what's very clear is that in most Western type diets we take a good deal of the insoluble fiber; we have diets that are very high in pastas and breads and wheat-containing products, broadly speaking.

And even if we take our sort of so-called five portions of fruit and vegetable a day, for most people that doesn't bring in much more than 10 to 15 grams of fiber a day. And you put into context that for the optimal fiber intake in terms of numbers is about 25 grams of fiber a day for a woman and about 35 grams for a man, you can

---

---

see that for most of us we're getting most of our fiber from cereal fibers, rather than necessarily from the fruit and vegetable fiber. And it's clear that this so-called soluble fruit and vegetable fiber is probably the way we should be taking our fiber, rather than cereals.

So the messages that we try and give patients is to sort of think about making sure you take enough fruit and vegetable so that you get that bulk of soluble fiber into your diet, and not overdoing the wheat and cereal fibers, which tend to cause more gaseousness, bloating, distension, those very uncomfortable symptoms of patients.

Seems to me as well as if a practical point of view, people don't necessarily like increasing fiber, so they tend to do it at a single meal, which I think is actually the worst thing to do. I try to encourage the sufferer to spread the total requirement across the two or three meals of their day which is much easier to tolerate.

You're absolutely right. I think a lot of my patients, I must say, have this thing about sprinkling on their breakfast or getting the bad stuff out of the way, but, like you do when you're a child, you think, "Well, I'll get that over." And so they start their day off with this terrible distension, which then, of course, gives them a miserable day often times.

And I think another point that you and I discussed is that if you are increasing, and some people are only taking 5 to 7 grams a day then you should take maybe three months to get up to 15 to 20 grams or above, that if you go out the next day and say, "I'm going to do the fiber," that you actually start to run into the problems that are so readily described.

Well I think you're absolutely right on two counts. One is this issue about sort of going at it bull at the gate, sort of quickly to get it in, but then equally expecting rapid results. That's the other problem with this approach, is that if you do it too hard and expect too much, actually you don't let your body adapt to this. Because what fiber is doing to your gut is to alter some of the chemical and physical changes in your tummy rather than just having an instantaneous switch on a light effect. So I think we have to counsel patients about what to do and what to expect.

So any final comments Pali or Eamonn on this dietary approach to IBS?

---

---

Well, it's very important from the point of view of the family doctor. I think the first question patients will ask is, "What can I do diet-wise to make myself better?" I think a good general approach is probably to say, look, why don't you try reducing wheat or any other item which you think might be responsible for triggering your symptoms? But I think the key here is if you're going to eliminate anything for a period of time, it has to be done for a minimum of two weeks, perhaps a month. And if that hasn't worked it's okay to go back on that and then perhaps to try something else. But once you've tried two or three things and they haven't worked or if they have worked, fine, but if they haven't worked, you should go back to eating a normal diet. The message there is your problem is probably not going to be solved by altering your diet.

Eamonn, what about probiotics, which we haven't mentioned, where an additional factor within the spectrum of diet?

Well, I think there's now good evidence from a number of large research studies that, in general, probiotics help irritable bowel syndrome, and they seem to be especially helpful for bloating and flatulence. And there are some probiotics that actually help a lot of IBS symptoms. But I would emphasize the point that Pali has just made, you know, just don't take a probiotic for a day and expect a miracle; you should give them an adequate trial and the research would say that that should be at least four weeks.

Now the question I'm always asked, because we've done research in probiotics, is what's the best one? And I can't give you a definitive answer here because it will depend on where you live and what probiotics are available to you and what particular symptoms you have. But some might be better for diarrhea, some might be better for constipation.

But what I would say is to use products from a reputable manufacturer and to look for evidence from them that this particular product actually helps irritable bowel syndrome. Another important point to make is that if they do work you need to keep taking them, because once you stop you lose the benefit.

And there's one other point I'd like to make about what Pali said about diet, and I think it's a very important one, and that is it's sometimes helpful for patients to keep a food diary. And it's sometimes as helpful when they see; well actually it doesn't matter what they eat, they get worse, because they can't identify a particular food. And there what we're probably dealing with is

---

---

normal physiology, that when we all eat we stimulate the bowel, and we stimulate the bowel because the main function of the bowel is to deal with food. So whether it's motility or secretion or any aspect of bowel function is stimulated by eating, so your symptoms get worse. And it's very helpful for the patient to say, "Well actually I thought it was this causing it, but then actually everything causes it," and that can often be just as helpful as is the case you mentioned, where they identify particular food that's a problem and then they try excluding that.

But if the food diary is associated with the life events diary where they can actually see that there may be other factors, like the bank manager telling them that they have overdrawn. That's right.

Or some other life event, which relates the stress-related factors.

Absolutely. I think that's absolutely key. And that's what I meant really, is that is having a food diary and then relating that to these episodes or bouts or attacks of symptoms that I've mentioned.

---