

# Why people with IBS may need to ban the bran



*Peter Whorwell explains that there is no simple dietary solution to irritable bowel problems*

Irritable bowel syndrome (IBS) has no respect for age and can be seen in the very young and in the very old. Most patients ask what can be done from a dietary point of view and nearly always request a 'diet sheet' which, as will become clear, is not a realistic option.

It has been traditional to recommend a high-fibre diet to patients with IBS, with particular emphasis on wheat fibre. However, recent research has suggested that wheat fibre is not suitable for all patients and can indeed make the condition worse (Figure 1). As might be expected, it is more poorly tolerated in patients with a loose bowel habit but, somewhat surprisingly, can even make some constipated patients worse. It also tends to exacerbate distension and can often lead to excessive passage of wind.

In order to establish whether wheat fibre is a problem, patients should be advised to avoid it *completely* for approximately 6–8 weeks — even the occasional slice of brown bread can upset some subjects for several days. If, after this period of time, they are no better then they can relax their diet. Obviously, if they are better they should continue with this particular dietary exclusion.

It is important to appreciate that patients need only exclude unrefined wheat products as they are seldom intolerant of 'wheat as a whole' — thus white bread, white pasta and white flour are fine. However, it is important not to forget that wheat fibre is present in products such as digestive biscuits, some crispbreads and cereal bars.

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With respect to cereals, we usually advise just rice crispies for the exclusion period and, although other cereals such as cornflakes are often well tolerated, this question is usually better answered at a later stage.

Sometimes, particularly if a patient has a tendency to constipation, wheat fibre exclusion can lead to a more sluggish bowel habit even though their pain and distension may be helped. In this situation, a proprietary form of soluble fibre such as an ispaghula preparation may be helpful. Lactulose can be tried but does tend to cause distension and excessive wind in patients with IBS.

Other foods can sometimes cause problems and exclusion diets have been widely recommended in IBS. However, they are quite cumbersome and are difficult to undertake without the necessary support from an experienced and interested dietician. A more pragmatic approach to dietary exclusion is often just as rewarding, using a similar system to that recommended for wheat fibre withdrawal. Patients are advised to exclude one food item at a time for 6–8 weeks and then assess whether or not there has been an improvement. It is important to emphasise to the patient that exclusion of food must be followed by an *unequivocal* improvement and that other factors, such as stress, may lead to simultaneous fluctuations in the severity of their symptoms.

Unfortunately, there seems to be no consistent pattern in what upsets a particular patient and a

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food which can upset one individual can be eaten with impunity by another. If there is little change in their symptomatology, they can be reasonably assured that this particular item is not a major problem. Obviously, this approach is useful in assessing the effect of more simple items such as specific vegetables, caffeine, chocolate, fats etc, but is not so easy with more complex foods. For example, it is important to bear in mind that an apparent intolerance of milk could be due to the protein, the fat or the lactose.

True 'food allergy' seems to be relatively rare in IBS and the majority of problems with food are more in keeping with 'intolerance'. There are a variety of tests for food allergy and intolerance,

varying widely in their plausibility. None have so far been submitted to rigorous scientific scrutiny and the highly desirable goal of having a blood test for identifying a specific intolerance is still awaited.

Some symptoms of IBS may be more related to diet than others and this seems to be particularly the case with abdominal distension and wind. Again, wheat can be a quite potent cause of wind but other foods, particularly vegetables, can be a problem and need to be tested individually. It is now being recognised that some sugar substitutes such as sorbitol can lead to wind and, if they are present in something like chewing gum, can be even more troublesome.

It should be remembered that the process of eating, rather than what is eaten, can also provoke the symptoms of IBS. This was elegantly demonstrated some years ago when sham feeding was seen to produce nearly as much physiological change in the gut of patients than actually swallowing the same food. Some patients even claim that if they did not have to eat, they would be fine. Needless to say, this pattern of activity can be worrisome, particularly if the patient has a tendency towards an eating disorder.

It is clear that patients vary considerably in what foods they 'react to' and that a diet sheet is not practicable. It is best to educate the patient fully in the complexities of the subject — ie. the differences between food allergy and intolerance, and the physiological response to eating — and let them decide for themselves. Lastly, it is extremely important to be cautious about the possibilities of encouraging an obsession about dietary factors. ■

Figure 1. Overall symptomatic response to fibre<sup>1</sup>

Fibre source	Better	Worse	Unchanged
Bran	11 (11%)	55 (55%)	33 (33%)
Cornflakes	0	0	88 (100%)
Rice crispies	0	0	81 (100%)
Porridge	0	9 (12%)	66 (88%)
Muesli	0	21 (27%)	58 (73%)
Vegetables	3 (3%)	24 (25%)	71 (72%)
Fruit	5 (5%)	42 (45%)	47 (50%)
Pulses	0	22 (25%)	65 (75%)
Nuts	0	23 (27%)	61 (73%)
Proprietary fibre	27 (39%)	15 (22%)	27 (39%)

(Reproduced from the *Lancet* 1994; **344**: 39-40.)