

Transcript Details

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Addressing the Nutritional Concerns of IBD Patients

Ms. Rubin:

Hi, I am Michele Rubin from the University of Chicago Hospitals and IBD Center, and today I have with me Ashley Perkovich, who is also from the University of Chicago IBD Center, and today we're going to talk about nutrition in inflammatory bowel diseases.

Ashley, do you want to get us started on what really are the issues and what are the nutrition concerns in IBD

Ms. Perkovich:

Yes, absolutely. So, decreased nutritional intake and increased losses, such as poor digestion and malabsorption, can occur as a result of many things, such as increased energy expenditure during flares, certain medications, such as steroids, methotrexate or sulfasalazine, restricted diets, bacterial overgrowth, the location of disease, and also if they've had a previous surgical reconnection.

Ms. Rubin:

So, Ashley, can you talk to us a little bit more about the malnutrition piece in IBD?

Ms. Perkovich:

Yes, absolutely. Oftentimes, there is a loss of appetite due to things like abdominal pain after eating, nausea, vomiting. Oftentimes, it is accompanied by weight loss. People have fear of eating certain foods. And also, the poor digestion and absorption can cause unwanted things such as gas and bloating and diarrhea, especially in those Crohn's patients. The most common deficiencies that I like to assess for routinely in my patients include folate, vitamins A, E, D and B12, iron, zinc, calcium, phosphate, copper, magnesium, potassium and selenium in patients with small bowel disease.

Here is a helpful resource for you to keep on hand when you're treating patients. Patients with iron and vitamin B12 deficiencies often feel fatigued. Calcium and vitamin D are another common deficiency that many patients have, especially patients who live in areas with little sun exposure. Zinc deficiencies can lead to delayed wound healing, and also, potassium and magnesium for patients that have chronic diarrhea or ostomies, it's really important to check in those patients, as well.

So, Michele, what are some nutritional issues with our surgical patients?

Ms. Rubin:

Well, to start, when there's resection of the bowel, and particularly the small bowel—that is where a lot of the nutrients are being absorbed—so if there are a lot of resections, they can develop short-bowel syndrome. Ileostomy has specific concerns to it, the J-pouch, patients who have bowel strictures or obstructions, in short-bowel, that's a malabsorption disorder that is caused by a lack of functional small intestine. Patients who have multiple ileal resections are particularly at risk of developing the short-bowel syndrome, and therefore, that leads to a high risk for malnutrition due to the diarrhea and the dehydration such that some of them may require chronic TPN, and these patients, in particular, need to be sent to a nutritional specialist.

Then there are the patients with ostomies. Location is key with an ileostomy. Ileostomies produce looser output than a colostomy because the colostomy is from the colon so there is more absorption of water there, and patients without the colon then have the ileostomy, so the colon is not taking the water out anymore so they have to, definitely, eat differently and choose foods differently. Nutrition loss: frequent, loose, watery stool decreases absorption of nutrients and weight loss, and then you have the dehydration with high ostomy output, or if they're not taking in enough fluids. Here is a chart that is a really good resource for ostomy patients, but in particular in looking at their nutrition is the column on the right that talks about how to thicken stool. It's very important to discuss with these patients the type of foods that they should be eating in order to thicken the stool output.

These are some of the main tips that I use for patients with an ileostomy. I tell them, usually, to eat small, frequent meals, 5 to 6 per day. They need to be snacking throughout the day between meals. They should definitely eat first, then drink, so that the food that they're ingesting can soak up the water, and thus, it slows down the transit time through their body. Avoid concentrated sweets and simple sugars because it speeds right through. Salt their food liberally. Achieve a thickened stool output 80% of the time. I feel this is a good measure that patients can understand, like within 24 hours. If they get it thickened 80% of the time, they're probably not going to get dehydrated. And then they can use the antidiarrheal products like Imodium or Lomotil before meals and at bedtime, and we tell them do not read the box because it doesn't fit them. They can take up to 8 tablets a day.

Ms. Perkovich:

And, Michele, what about patients with J-pouch? What nutritional concerns do they have?

Ms. Rubin:

So, the issues with the J-pouch is they have no colon, so they have looser, more frequent stools; they also have a temporary loop ileostomy as a second stage, and that's different from an end in that it bypasses 20% of the small bowel, so their output is more watery. A J-pouch, made from the terminal ileum, and we know that absorption of vitamin B12 and some of the nutrients that you had talked about earlier are absorbed in the terminal ileum, so that's an issue. The rectal cuff that is left in is 1 to 2 cm, and that can be a source of bleeding if it becomes active colitis. Pouchitis: 50% of the patients develop an infection that causes diarrhea, as well as you have C. diff. Both of these cause watery, loose stools. The cuffitis is the bleeding. So, the nutrition loss is from the frequent loose, watery stools that decrease absorption. They get weight loss. Bleeding is, there again, your iron loss and anemia. Terminal ileum as a J-pouch, decreased absorption of the vitamin B12. Also, the bile salts are reabsorbed here, so they aren't getting reabsorbed and cause diarrhea—and then your folic acid, magnesium, vitamin D, iron, etc. Bacterial flora overgrowth is another issue that can decrease absorption of nutrients and cause diarrhea, so a lot of issues.

Ms. Perkovich:

Absolutely. Do you have any tips for these patients on things that they can do?

Ms. Rubin:

Oh, yes, Ashley. Number one, I tell them keep stools pasty and low in number. Eat first, then drink. Sip fluids with snacks. Keep the stools between 4 to 8 per day, best is 5 to 6, pasty again 80% of the time. Use the antidiarrheals. Fiber preparations can also help. Use food and stool diaries. This is sort of the patient's way of self-management in learning how food affects their stool output and when it is occurring after eating. and surveillance nutritional deficiencies yearly or if you have any concerns at any time.

Ms. Perkovich:

What about patients that have known strictures?

Ms. Rubin:

Sure. Eat a low-fiber diet, no raw fruits or vegetables, peanuts or corn, shrimp or mushrooms. All of these do not break down well in our system. Moderation with food intake, taking in small amounts at a time, drink plenty of fluids to help flush things through, and I also tell them to walk around, stimulate intake to move things through after meals.

Ms. Perkovich:

That's great, Michele.

So, Ashley, what do you tell patients who are in a flare?

Ms. Perkovich:

Yes, so most importantly they should try to limit their stress. Obviously, patients that are experiencing high amounts of stress or going through a life change, such as divorce or getting married, those patients are often the ones calling your office that they're flaring, so limiting stress is key. I also tell them that during this time of a flare they should be reducing their fiber intake, especially things such as raw fruits and vegetables, nuts, seeds, and they should really be increasing easily-digested proteins such as fish, chicken, eggs, nut butters. They also need to watch the high-fat foods and fried foods, as those can also increase the number of bowel movements they're having, and they should reduce their caffeine and intake of carbonated drinks.

Ms. Rubin:

So, Ashley, diet is always a question with patients. I mean, we hear this every day. Can you tell us a little bit about that?

Ms. Perkovich:

Yes. There are so many diets out there, many fad diets that are popular now, and I'm sure there will be more to come. I think the main point to drive home with these patients is that, although a diet can help with symptoms, it doesn't heal inflammation associated with

Crohn's and colitis, so if a patient wants to follow a specific diet, they can, but they need to do it in combination with medical therapy. Again, the only thing I really do recommend is that they limit their fiber during flares, so I say a low-residue diet during flares, and also remember to rule out celiac disease in at-risk patients.

Ms. Rubin:

Ashley, can you sort of sum it up a little bit for us on nutrition in IBD?

Ms. Perkovich:

So, I think it's important to check for vitamin and mineral deficiencies routinely in these patients, especially in patients with ileal disease, history of bowel resection and our J-pouch patients. I check them at least annually, sometimes more. And, also, make sure you're checking vitamin D levels, even if your patient is well and has been in remission for years. Collaborate with your dietician for supplementation recommendations, especially in those really tough patients who have multiple deficiencies, have weight loss, malnutrition, short-bowel syndrome or that require TPN. Nutrition counseling really empowers our patients.

There is a dedicated nutrition web page for both providers and patients on the Crohn's and Colitis Foundation website. Please visit www.crohnscolitisfoundation.org for these resources.

Ms. Rubin:

Thank you, Ashley, for an excellent presentation today. I think this was a great discussion that is very much needed for providers but also a very important issue for our patients. So, thank you, Ashley, for joining me today.

Ms. Perkovich:

Thanks, Michele.