

Dietary advice and Crohn's disease – facts or folly?

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Julie Cepo (nee Robers) is the inpatient clinical dietitian for the Gastroenterology Program at Mount Sinai Hospital in Toronto, Ontario. She specializes in parenteral and enteral nutrition support, as well as in perioperative therapeutic diet education. She is the co-author of the *Crohn's & Colitis Diet Guide*.

PA: It seems that no matter how much I try to educate a patient with Crohn's disease they always come back with the idea that their disease is caused by diet.

JC: I would agree that this is a common misconception for those living with Crohn's disease and ulcerative colitis, and is also understandable. It is often during times of disease activity that individuals experience pain with or after eating, creating a strong association between diet and symptoms. It is natural that they would make a connection between diet and disease.

If you are living with an unpredictable chronic disease, diet can provide a sense of control and hope. Anecdotal stories of a cure or promises of preventing recurrence through diet are very powerful, but unfortunately, many patients then internalize a responsibility for their disease. Currently, there is no evidence to support the role of diet in disease perpetuation and I advise patients that what they eat will not cause or cure their disease. The intent is to absolve them from feeling responsible for causing their disease.

The flipside is that dietary factors may play a role in triggering the disease in a genetically susceptible individual; however, there are few research studies that have examined the link to foods or dietary constituents (eg, additives, foodstuffs, specific proteins, microparticles, etc), and for obvious reasons. Diet is tremendously difficult to study, considering the presence of so many confounding factors. I can say from my experience working in a large, urban-based hospital, that I see tremendous variation in diet for ethnic, cultural, religious, financial, and philosophical beliefs and reasons. Inflammatory bowel disease (IBD) occurs in individuals who consume very different diets.

PA: What are the objectives for diet advice in the Crohn's disease patient?

JC: The primary goal is to empower the individual (and his or her family) living with IBD to make informed choices regarding diet and to improve quality of life, mostly by helping with symptom management. Diet advice should be individualized



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and negotiated; realistic, consider disease status, anatomy and treatment; consider lifestyle factors such as taste preferences, tolerances, phobias, etc; ensure nutrient variety (eg, compare diet with *Canada's Food Guide for Healthy Eating*) and provide suitable alternatives or supplements if needed. Facilitating comprehensive diet advice will always be a challenge for the health care provider because it takes time to ask, listen and counsel.

Specific examples of objectives in an acute care setting include managing symptoms (eg, normalizing bowel function by reducing frequency or increasing consistency of stool, reducing gas and cramping, adopting temporary or longer-term therapeutic diets, etc); improving nutritional status (eg, maintaining or repleting weight in adults, promoting growth in children and adolescents, ensuring balanced provision of nutrients, preventing and correcting nutrient deficiencies); maintaining

hydration and electrolyte balance; and promoting social participation and enjoyment of eating (eg, improving relationship with food and normalizing diet).

PA: We have seen so many diets come and go for Crohn's disease. It gives many physicians the idea that no particular diet is recommended or proven to be helpful.

JC: This is correct. There is no single diet that works for everyone with Crohn's disease or ulcerative colitis. It would make things so much easier if we had an 'IBD diet'; however, a disease that presents with different characteristics, complications and symptoms in different people requires individualized diet strategies to manage these symptoms.

PA: Patients will often try a gluten-free or lactose-free diet even though they do not have those specific diseases or conditions. Can you comment on exclusion diets and 'miracle cures'?

JC: Living with a chronic, unpredictable disease often leads individuals to test dietary approaches to manage their disease. I see this quite regularly in my practice, and the list of foods excluded can be quite comprehensive. My concern with exclusion diets are the potential consequences: nutritional deficiencies, weight loss and feeling responsible for the recurrence or worsening of disease when the individual 'cheats' on the diet. The usefulness of exclusion diets has been challenged in the literature; research studies have shown that relapse does not always occur when the suspected and/or excluded foods were reintroduced.

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There are many IBD 'fad' diets, and some dietary eliminations commonly seen include wheat/gluten, dairy, red meat, refined sugar, yeast, caffeine, spices and alcohol, to name a few. There are also supplements marketed to IBD sufferers that tout healing of inflammation or enhanced immune function. These dietary practices are not my recommendation; however, my role as a dietitian affords me the opportunity to develop a relationship and trust with a patient, learn about their diet, explore their rationale and experiences, carefully challenge and educate, and ultimately respect their autonomy. I need to assess for potential nutritional deficiencies and advise acceptable alternatives, or suggest supplements for the excluded nutrients. I may not agree with their decision; however, if the patient has made an informed choice and perceives improvement from dietary changes, it is my responsibility to help – and I may even learn something from their experience.

PA: You have written a recipe book on Crohn's disease. Is there an underlying concept to the recommendations?

JC: I believe that the diet guide, which I co-wrote with my colleague from Mount Sinai Hospital, Dr Hillary Steinhart, is informative and written in an easy-to-understand manner. It is meant to help sort out diet myth from science and to enable individuals (and their families) living with IBD to make more informed choices for their own individualized diet and symptom management. It provides information regarding medical and surgical therapies, diet modification goals and tips, nutrition facts and answers to common questions, to name a few features.

PA: In many medical centres, it may be difficult to access a dietitian. How do patients access your advice and are these services readily available (ie, public versus private)?

JC: I have been struck by the large audiences at public educational events where I have spoken about diet and IBD, and I have also been struck by the number of individuals who 'swarm' after the formal presentation so that they can ask more questions. This is testament to the fact that there is not enough access to dietitians. Patients of Mount Sinai Hospital are fortunate because they have access to dietitians who are experienced in managing patients with IBD. Unfortunately, such access is not widely available across all communities or hospitals.

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There are private practice dietitians with a special focus in gastroenterology that can be located by accessing the Dietitians of Canada Web site <www.dietitians.ca>, specifically under 'find a dietitian', or one could access a provincial call centre (province/territory dependent).

One of the motivations for writing the *Crohn's & Colitis Diet Guide* was to share my experience and knowledge to help patients, families and other health care providers.

PA: How do you quickly assess the nutritional status of your patient?

JC: First, identify risk factors for malnutrition. Look for inadequate intake (anorexia, intolerance, dysgeusia, dysphagia, sitophobia, odynophagia, elimination diets, dependencies and dentition), increased requirements (steroids, infection, fever, inflammation and growth), malabsorption (decreased absorptive surface, nutrient bypass, drug interference and bacterial overgrowth) and increased losses (blood, fistula, protein-losing enteropathy, vitamins and minerals, and trace elements).

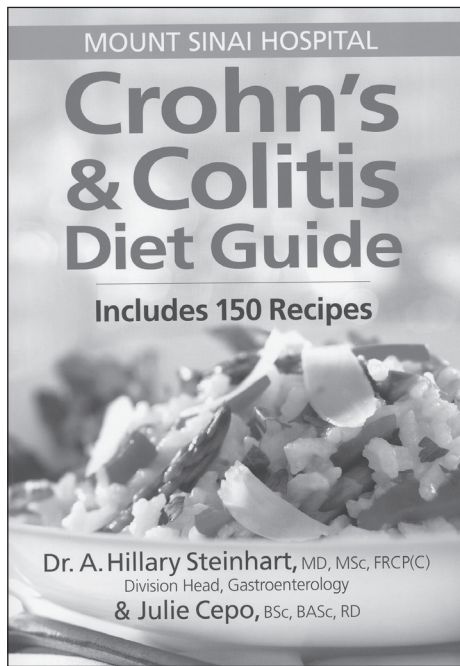
Second, assess for weight change (weight history, functional capacity and body composition).

Third, ask about the patient's usual diet intake, specifically changes in quantity and quality. Are they eating foods from the four food groups described in *Canada's Food Guide to Healthy Eating*? If any food groups are avoided on a regular

basis, nutrients will be limited, which places them at risk for deficiency.

PA: What can the busy physician learn from the dietitian about the long-term management of their patient?

JC: Diet is usually of high interest to patients. Help them sort out myths or pseudoscience from scientifically based data and practices. Listen to their experiences, but provide your perspective. Refer them to reliable evidenced-based strategies. Nutrition is also important for your management of patient outcomes – changes to diet or weight are risk factors for malnutrition, which, in turn, affects immune function (eg, sepsis rates), wound healing and tissue repair, and long-term complications (eg, osteopenia). Remember that there will always be someone whose experience with diet is different from what we would expect! A little diet knowledge goes a long way in developing rapport and a positive, therapeutic relationship.



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