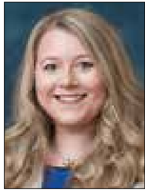
ADVANCES IN IBS

Current Developments in the Treatment of Irritable Bowel Syndrome

Section Editor: William D. Chey, MD

Irritable Bowel Syndrome, Disordered Eating, and Eating Disorders



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G&H What is the difference between disordered eating and an eating disorder?

KH Disordered eating occurs when individuals regularly engage in eating patterns that do not follow the cultural norm—for example, skipping meals, limiting foods, or following a restrictive diet (eg, Paleo or ketogenic). Disordered eating is often seen in irritable bowel syndrome (IBS) as a way to avoid or prevent symptoms. For example, patients may skip meals at work or school to avoid bloating, abdominal pain, or diarrhea. The difference between disordered eating and an eating disorder is the severity of behaviors, motivation driving the behavior (eg, body dysmorphia), and the negative medical or psychosocial effects caused by the behaviors. Patients with eating disorders display disordered eating, but not all disordered eaters have an eating disorder. What clinicians need to be aware of is when disordered eating habits shift from being a reasonable response to an underlying gastrointestinal (GI) condition to pathologic behaviors that cause physical or psychosocial impairment.

G&H What is the current understanding of the relationship between IBS, disordered eating, and eating disorders?

KH Food-induced symptoms are common among adults diagnosed with IBS, and symptoms associated with IBS are often responsive to dietary changes. Given the dietary-responsive nature of IBS, patients often implement self-driven dietary restrictions to control their symptoms, and clinicians will often prescribe restrictive diets as therapy for their patients' conditions. Although dietary restriction is generally appropriate and not associated with harmful consequences, the restrictive practices that are implemented (either by the patient or through prescribed therapy) can progress and place individuals at risk for development of disordered eating patterns. These patterns can lead to pathologies such as weight loss, inadequate nutrition, and significant psychosocial impairment.

G&H How prevalent are disordered eating habits among patients with IBS compared with the general population?

KH This is definitely an area requiring more investigation. Unfortunately, most of the current data highlight the prevalence of IBS among patients with eating disorders, and less is known about the prevalence of eating disorders and disordered eating among IBS patients. We do know that disordered eating behaviors are increased in adult IBS patients compared with non-IBS patients, with study results ranging from 15% to 25% vs 3%. A systematic review demonstrated that approximately 23% of patients with GI disease had disordered eating habits, which is higher than the 10% prevalence rate reported for the general population.

G&H Are certain subtypes of IBS more likely to be associated with eating disorders?

KH Again, the majority of studies on this topic have come from psychologists evaluating the prevalence and impact of functional GI disorders or IBS in patients who have an eating disorder, and evidence is lacking from gastroenterologists researching eating disorders among patients with IBS. Studies have shown that over 90% of patients with anorexia or bulimia have functional GI symptoms, but I am not aware of data associating a specific subtype of IBS with an eating disorder.

G&H What is known about avoidant/restrictive food intake disorder?

KH Avoidant/restrictive food intake disorder (ARFID) was first included in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* in 2013, with a proposed subgroup highlighted by pathologic restriction resulting from a fear of negative consequences associated with oral intake. Currently, much of the research has been performed in pediatric and adolescent populations. There is very limited evidence regarding the role of ARFID in adult populations, and essentially no evidence evaluating ARFID in the adult GI population. However, as discussed previously, GI patients are particularly at risk for disordered eating practices. Individuals with dietary-controlled GI disorders such as IBS often experience uncomfortable and distressing symptoms associated with oral intake. Those symptoms are then associated with negative outcomes by the patient, and patients can develop a conditioned or fear-based food aversion. This response can progress into disordered eating patterns to the point where patients are afraid to eat a wide variety of food and dramatically restrict their diet. Those restrictions can result in weight loss, malnutrition, dependence on tube feeds or supplement beverages, or significant psychosocial impairment.

My colleagues and I conducted the largest study to date regarding the prevalence of ARFID among adult GI patients. The results, which were presented at the 2018 American College of Gastroenterology meeting, demonstrated that 19% of patients from the adult outpatient GI clinic screened positive for ARFID. Further, IBS patients were twice as likely as non-IBS patients to screen positive.

G&H How should adult patients be screened for ARFID?

KH The nine-item ARFID screen (NIAS) is a screening questionnaire that was validated in a general adult population. NIAS can be used to screen for ARFID among GI patients; however, the GI patient population is different than the population NIAS was developed in, and the validity is a bit unclear at this time. Thus, the questionnaire is just part of the conversation that physicians should be having with patients, and screening is more clinically based at this time. Clinicians should be concerned if they notice red flags such as severe food restriction or lack of reintroduction of foods, fear associated with foods, weight loss, dependence on nutritional supplements or tube feeds, or a discordance between the patient's clinical diagnosis and the severity of dietary restriction.

G&H How can clinicians identify an eating disorder in their patients?

KH Clinicians should be aware that eating disorders and GI disorders occur concomitantly. Patients can have IBS or another GI disorder as well as disordered eating or an eating disorder. Understanding that these disorders occur simultaneously is important, but it is also necessary to identify red flags, including progressive restriction within an already restrictive diet, refusal to reintegrate foods during a reintroduction protocol, discordance of clinical presentation or history with clinical data, evidence of body dysmorphia, or a lack of concern with a severely restrictive diet or weight loss. It is often challenging to tease apart GI symptom–driven dietary changes from eating disorder–driven restriction, and an open and thorough history is required.

G&H How should patients with IBS who have an eating disorder be treated or managed?

KH Disordered eating or an eating disorder can complicate the clinical picture of a patient with IBS. There is concern with overmedicalizing patients and not recognizing the role of disordered eating or an eating disorder vs overattributing the patient's GI symptoms to the psychological process. Awareness is key. Treatment requires a multidisciplinary approach, including members from gastroenterology, psychiatry, psychology, and nutrition. Excellent communication between the providers is imperative because dietary restriction can be driven simultaneously by GI and psychological processes. Importantly, gastroenterologists should not attribute all GI symptoms to the eating disorder or disordered eating, as evidence has shown that many of these patients continue to have GI symptoms even after eating disorder control is achieved.

G&H What are functional foods? Do they have a role in treating IBS patients with eating disorders?

KH Functional foods are whole foods that potentially have a positive effect on health beyond their basic nutri-

tional value when eaten as part of a varied diet on a regular basis. Functional foods include yogurt or kefir, which are probiotic-containing and promote digestive health, as well as kimchi, kombucha, and sauerkraut, which are prebiotic-containing fermented foods. High fiber–containing foods are particularly used in GI patients to treat constipation and IBS symptoms.

There is a growing awareness and interest in treating IBS with probiotic- or prebiotic-containing foods. Patients with eating disorders or disordered eating tend to restrict foods from their diet and avoid integrating new foods. Thus, it can be challenging to add a specific dietary therapy into their diet. It is yet to be determined if functional foods have a role in treating IBS patients with eating disorders.

G&H Are there any subsets of patients with IBS who would not benefit from an elimination diet?

KH Patients are often appropriately prescribed restrictive or elimination diets as part of therapy for a variety of gastroenterology disorders, including IBS. However, clinicians need to be cautious when prescribing restrictive diets to patients who have an eating disorder history or evidence of restrictive dietary practices. Additional high-risk groups include patients with an underweight body mass index, patients who are actively losing weight, and patients who are already consuming a very restricted diet. Until better methods to risk-stratify patients are available, clinicians should strive to understand their patients' dietary habits to ensure that significant restriction has not already been implemented. Clinicians should also ask about prior struggles with eating disorders or restrictive eating habits.

G&H What research is needed in this field?

KH Most of the research in this field has been driven by psychologists and dietitians. However, there is growing interest among gastroenterologists regarding gaining a better understanding of the potential harms of prescribing restrictive dietary therapies, as well as how to effectively risk-stratify patients when prescribing restrictive diets. It is imperative for gastroenterologists to be aware of disordered eating as well as eating disorders, and it is important to understand and appreciate that GI disorders and disordered eating occur concomitantly. One of my goals is to raise awareness of ARFID and how it complicates the clinical picture of GI patients. If clinicians are not aware of ARFID, they do not look for it, and if they do not look for it, they cannot appropriately treat it. If ARFID is not identified and subsequently treated, patients can be prescribed inappropriate restrictive diets or receive unnecessary testing or pharmacologic therapy.

Dr Harer has no relevant conflicts of interest to disclose.

Suggested Reading

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