

Dietary Recommendations in Inflammatory Bowel Disease

The American Gastroenterological Association recommends a short-term reduced-fiber, low-FODMAP dietary approach during symptomatic IBD flares, with a return to a Mediterranean-style diet as symptoms resolve.[1] This represents a significant shift from traditional long-term low-residue recommendations.

During active flares, patients may benefit from temporarily limiting fermentable oligo-, di-, and monosaccharides and polyols (FODMAPs), which can worsen symptoms through osmotic effects and fermentation-induced luminal distension.[1][2] However, the AGA cautions against prolonged use of low-FODMAP diets because they reduce beneficial fecal microbiome organisms and decrease butyrate production—a key nutrient for gut epithelial health.[1] The organisms diminished by low-FODMAP diets are paradoxically associated with endoscopic and clinical remission when abundant, raising concerns about long-term consequences.[1]

As symptoms improve, patients should transition to a Mediterranean diet rich in fresh fruits and vegetables, monounsaturated fats, complex carbohydrates, and lean proteins, while minimizing ultraprocessed foods, added sugar, and salt.[1] This approach may improve gut microbiome diversity and offers additional health benefits including reduced cardiovascular disease risk.[1] Patients can better tolerate fibrous foods by modifying texture through cooking, blending, and thorough chewing.[1]

Specific foods to avoid include sugar-sweetened beverages, which have been linked to a more severe disease course in prospective studies.[1] The AGA notes that no diet has consistently been shown to decrease flare rates in adults with IBD, though a diet low in red and processed meat may reduce ulcerative colitis flares.[1]

For patients with mild to moderate symptoms, a Mediterranean-style diet can be introduced even during the flare.[1]

Beyond these general principles, specific dietary patterns have been studied for their ability to induce remission during active flares, particularly in Crohn's disease. Exclusive enteral nutrition (EEN) remains the most established dietary therapy for active CD, especially in pediatric populations, though adherence challenges limit its use in adults.[3] The Crohn's Disease Exclusion Diet (CDED) combined with partial enteral nutrition offers a more palatable alternative that has shown promising efficacy in both children and adults with active disease.[4][5]

Whole-food-based exclusion diets have demonstrated variable success in achieving clinical remission. The Specific Carbohydrate Diet, which eliminates complex carbohydrates and processed foods, has been evaluated in several studies with mixed results.[4][3] A symptoms-guided diet approach achieved clinical remission in 50% of participants with active CD compared to 0% in control groups in one small trial, though the evidence remains a very low certainty.[6] Similarly, highly restricted organic diets and low microparticle diets have been studied, but the effects on clinical remission remain uncertain due to small sample sizes and methodological limitations.[6]

Common elements across effective dietary interventions include an initial elimination phase

followed by gradual reintroduction, emphasis on whole foods, and exclusion of ultraprocessed foods and additives.[7][3] The Groningen Anti-Inflammatory Diet (GrAID), designed based on comprehensive evidence review, recommends lean meat, eggs, fish, plain dairy products, fruits, vegetables, legumes, and wheat while limiting red meat and sugar and avoiding canned/processed foods, alcohol, and sweetened beverages.[8]

For ulcerative colitis flares, dietary evidence is more limited. Active UC may benefit from approaches that modulate microbial metabolism by reducing colonic sulfide production and enhancing short-chain fatty acid production through reduced animal-based foods and increased fermentable fibers.[9] However, the certainty of evidence for specific dietary interventions in active UC remains very low.[6]

Nutritional counseling by trained IBD dietitians is essential for implementing these dietary strategies, ensuring nutritional adequacy, optimizing adherence, and personalizing approaches based on individual tolerance and disease phenotype.[9][5]

References:

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