Diet and nutrition against inflammatory bowel disease: Trick or treat(ment)?

Salvatore Greco, Beatrice Bonsi, Nicolò Fabbri

Abstract

Even if the relationships between nutrition and inflammatory bowel disease (IBD) remain underexplored, the current literature is providing, day by day, much more evidence on the effects of various diets in both prevention and treatment of such illnesses. Wrong dietary habits, together with other environmental factors such as pollution, breastfeeding, smoke, and/or antibiotics, are among the theoretical pathogenetic causes of IBD, whose multifactorial aetiology has been already confirmed. While some of these risk factors are potentially reversible, some others cannot be avoided, and efficient treatments become necessary to prevent IBD spread or recurrence. Furthermore, the drugs currently available for treatment of such disease provide low-to-no effect against the symptoms, making the illnesses still strongly disabling. Whether nutrition and specific diets will prove to effectively interrupt the course of IBD has still to be clarified and, in this sense, further research concerning the applications of such dietary interventions is still needed.

Key Words: Crohn’s disease; Ulcerative colitis; Inflammatory bowel disease; Diet; Nutrition; Treatment

©The Author(s) 2022. Published by Baishideng Publishing Group Inc. All rights reserved.
Core Tip: The incidence of inflammatory bowel disease (IBD) is alarmingly growing worldwide, and there is still no efficient drug able to induce complete remission since IBD spreads. There is currently no consensus in the medical community about nutritional treatment for the IBD patients, and the role of diet in the disease course is often underestimated. Diet and nutrition seem to have a role not only in preventing the onset of the disease, but also in inducing and keeping temporary remission. Whether specific diets have potential to cure the disease is still uncertain and much research is still needed to clarify their role in this sense. In our opinion, diet and nutrition should be classified as pure treatments against IBD, as it happens for steroids, azathioprine, mesalazine, or others, and their administration should be indicated by nutrition specialists, with the greatest degree of customization of dosages and dietary plans.

Citation: Greco S, Bonsi B, Fabbri N. Diet and nutrition against inflammatory bowel disease: Trick or treat(ment)? World J Exp Med 2022; 12(5): 104-107
URL: https://www.wjgnet.com/2220-315x/full/v12/i5/104.htm
DOI: https://dx.doi.org/10.5493/wjem.v12.i5.104

TO THE EDITOR

Inflammatory bowel disease (IBD) is generally multifactorial and usually characterised by exacerbated immune response and epithelial barrier dysfunction. The intestinal epithelium is appointed to defend the host from bacterial and other microorganisms’ invasion and to control the passage of water and electrolytes. In the case of IBD, the integrity of the epithelial barrier gets severely compromised, with consequent destabilization of intercellular junctions (tight and adherens junctions)[1,2].

Pharmacological treatments include anti-inflammatory drugs, such as steroids, mesalazine, biological anti-tumor necrosis factor-α, or immunomodulators such as azathioprine[3], but they are usually not sufficient to keep disease remission or show low-to-no effects against temporary symptoms. Moreover, the high incidence of side effects has to be considered. Substantially, there is still no efficient drug able to induce complete remission since IBD spreads. In this sense, the development of alternative and “safer” treatments for preventing the disease or controlling its course, has taken hold over the last decade. Diet itself, together with smoke, pollution, breastfeeding, and/or antibiotics, is among the most important environmental factors predisposing to IBD. The beneficial effect of diet on both development and duration of the remitting phases is already known, even if nutritional supplements and macro- and micro-nutrients should be always adapted to patients, as they have different roles in preventing or inducing remission in Crohn’s disease (CD) or ulcerative colitis (UC)[4]. Furthermore, we would like to stress another aspect of the pathogenesis of such diseases, which is represented by intestinal dysbiosis (the altered composition of the gut microbiota), historically linked to numerous gastrointestinal diseases (including malignancies and chronic hepatitis B and often precipitated by the constant and increasing use of antibiotics in our society[5]. The current literature is full of examples of how intestinal dysbiosis can potentially affect the epithelial integrity, progressively leading to the development of chronic inflammatory diseases, but the exact mechanism of such damage is still far from being fully understood and deserves some more attention.

The gut microbiota of individuals with IBD is characterized by low microbial diversity in general, and a higher concentration of pathobionts such as adherent/invasive Escherichia coli and Clostridium difficile, Proteobacteria, and Actinobacteria, even if patients with CD have greater microbiota dysbiosis than those with UC[6-9].

Compared to the Mediterranean diet, the Western-style diet (WSD) contains significantly higher amounts of simple refined carbohydrates, saturated fat, red meat, dairy, and industrialized foods. Although the relationship between the WSD and IBD has only been partially studied, the WSD involves the use of nutrients capable of eliciting a direct or indirect pro-inflammatory effect on the intestine through alterations in the equilibrium among the immune system, microbiota, and intestinal barrier[10,11].

Food-induced changes in the microbiota have not yet been fully studied, but it is known that higher intakes of fibers, while favouring the production of small chain fatty acids by the microbiota, can exacerbate the symptoms in patients with IBD, especially during the acute phases. Furthermore, the excess of refined carbohydrates and dairy products and proteins has been shown to alter the gut microbiota by reducing the abundance of bacteria such as Roseburia and Eubacterium rectale, where are considered beneficial to health due to their ability to produce butyrate[12,14]. However, the most compelling studies on IBD have focused on the risk of high-saturation polyunsaturated fatty acids as a consequence of high meat consumption (especially red meat).

Another possible causative factor is represented by gluten: Its digestion gives rise to toxic and antigenic peptides (especially alpha-gliadin peptides), which can interfere not only with the tight junctions between enterocytes but also with enterocyte survival by affecting the whole intestinal barrier.
High-fat diets, in general, can lead to higher storage of secondary bile acids, such as deoxycholic acid, which can inhibit the growth of specific bacterial phyla such as Bacteroidetes and Firmicutes, thus resulting in intestinal dysbiosis similar to that found in IBD[15]. Also, the negative effect of non-caloric artificial sweeteners on the composition and functioning of the microbiome has been clearly highlighted by several studies, resulting in an increased risk of obesity, insulin resistance, and inflammation[16,17].

Enteral nutrition (EN), either elemental or nonelemental, is considered a plausible alternative to drugs for inducing IBD remission, and it is able to fight the nutritional gap induced by intestinal malabsorption during the acute phase of the disease. EN has been shown to have an anti-inflammatory effect in children with CD, and it seems to have a significant impact in the cascade of pathogenesis, even if the underlying mechanisms of action are not fully understood[18-20]. Basically, although conducted on small sized samples of patients, most studies seem to suggest that IBD-dedicated diets should reduce the overall quantity of meat, eliminate red and processed meat, and eliminate or strongly reduce gluten and dairy products (i.e., caseins), with the only exceptions of yogurt and kefir.

According to Levine et al[20] and after a quick review of the literature dedicated to this topic and with current knowledge, we can state that it is fundamental to customize the choice of micro- and macronutrients and supplemental nutrition for each patient; at the same time, it would be excessively superficial to consider the administration of such aids as tricks, only able to delay the spread of the IBD or the recurrence of their acute phases. In our opinion, diet and nutrition have to be classified as pure treatments against IBD, as it happens for steroids, azathiopirine, mesalazine, or others, and their administration should be indicated by nutrition specialists, with the greatest degree of customization of dosages and dietary plans.

FOOTNOTES

Author contributions: Greco S and Fabbri N designed and performed the research; all authors analyzed the data and wrote the manuscript.

Conflict-of-interest statement: All authors declare no conflicts of interest for this article.

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: https://creativecommons.org/Licenses/by-nc/4.0/

Country/Territory of origin: Italy

ORCID number: Salvatore Greco 0000-0001-7334-0135; Beatrice Bonsi 0000-0001-6320-5271; Nicolò Fabbri 0000-0001-7039-3717.

S-Editor: Wang LL
L-Editor: Wang TQ
P-Editor: Wang LL

REFERENCES

1 Matsuoka K, Kobayashi T, Ueno F, Matsui T, Hirai F, Inoue N, Kato J, Kobayashi K, Koganei K, Kunisaki R, Motoya S, Nagahori M, Nakase H, Omata F, Saruta M, Watanabe T, Tanaka T, Kanai T, Noguchi Y, Takahashi KI, Watanabe K, Hibi T, Suzuki Y, Watanabe M, Sugano K, Shimosegawa T. Evidence-based clinical practice guidelines for inflammatory bowel disease. J Gastroenterol 2018; 53: 305-353 [PMID: 29429045 DOI: 10.1007/s00535-018-1439-1]
2 Vargas-Robles H, Castro-Ochoa KF, Citalian-Madrid AF, Schnoor M. Beneficial effects of nutritional supplements on intestinal epithelial barrier functions in experimental colitis models in vivo. World J Gastroenterol 2019; 25: 4181-4198 [PMID: 31435172 DOI: 10.3748/wjg.v25.i30.4181]
3 Triantafillidis JK, Merikas E, Georgopoulos F. Current and emerging drugs for the treatment of inflammatory bowel disease. Drug Des Devel Ther 2011; 5: 185-210 [PMID: 21552489 DOI: 10.2147/DDDT.S11290]
4 Neuman MG, Nanau RM. Inflammatory bowel disease role: of diet, microbiota, life style. Transl Res 2012; 160: 29-44 [PMID: 22687961 DOI: 10.1016/j.trsl.2011.09.001]
5 Sobhani I, Tap J, Roudot-Thoraval F, Roperch JP, Letulle S, Langella P, Corthier G, Tran Van Nhieu J, Furet JP. Microbial dysbiosis in colorectal cancer (CRC) patients. PLoS One 2011; 6: e16393 [PMID: 21297998 DOI: 10.1371/journal.pone.0016393]
6 Ott SJ, Musfeldt M, Wenderoth DF, Haempe J, Brant O, Folsch UR. Reduction in diversity of the colonic mucosa associated bacterial microflora in patients with active inflammatory bowel disease. Gut 2004; 53: 685-693 [DOI: 10.1136/gut.2003.025403]
7 Sokol H, Lepage P, Seksik P, Doré J, Marteau P. Temperature gradient gel electrophoresis of fecal 16S rRNA reveals
active Escherichia coli in the microbiota of patients with ulcerative colitis. *J Clin Microbiol* 2006; 44: 3172-3177 [PMID: 16954244 DOI: 10.1128/jcm.02600-05]

8 Rodemann JF, Dubberke ER, Reske KA, Seo DH, Stone CD. Incidence of Clostridium difficile infection in inflammatory bowel disease. *Clin Gastroenterol Hepatol* 2007; 5: 339-344 [PMID: 17368233 DOI: 10.1016/j.cgh.2006.12.027]

9 Pascal V, Pouzelo M, Borruel N, Casellas F, Campos D, Santiago A. A microbial signature for Crohn’s disease. *Gut* 2017; 66: 813-822 [DOI: 10.1136/gutjnl-2016-31235]

10 Lindi JK. Dietary practices and inflammatory bowel disease. *Indian J Gastroenterol* 2018; 37: 284-292 [PMID: 30209778 DOI: 10.1007/s12664-018-0890-5]

11 Marion-Letellier R, Savoye G, Ghosh S. IBid: In Food We Trust. *J Crohns Colitis* 2016; 10: 1351-1361 [PMID: 27194533 DOI: 10.1093/ecco-jcc/jjw106]

12 Jantchou P, Morois S, Clavel-Chapelon F, Boutron-Ruault MC, Carbonnel F. Animal protein intake and risk of inflammatory bowel disease: The E3N prospective study. *Am J Gastroenterol* 2010; 105: 2195-2201 [PMID: 20461067 DOI: 10.1038/ajg.2010.192]

13 D'Souza S, Levy E, Mack D, Israel D, Lambrette P, Ghadirian P, Deslandres C, Morgan K, Seidman EG, Amre DK. Dietary patterns and risk for Crohn’s disease in children. *Inflamm Bowel Dis* 2008; 14: 367-373 [PMID: 18092347 DOI: 10.1093/ccion/j2.1.367-73]

14 Racine A, Carbonnel F, Chan SS, Hart AR, Bueno-de-Mesquita HB, Oldenburg B, van Schaik FD, Tjonneland A, Olsen A, Dahm CC, Key T, Luben R, Khaw KT, Riboli E, Grip O, Lindgren S, Hallmans G, Karling P, Clavel-Chapelon F, Bergman MM, Boeing H, Kaaks R, Katzke VA, Palli D, Masala G, Jantchou P, Boutron-Ruault MC. Dietary Patterns and Risk of Inflammatory Bowel Disease in Europe: Results from the EPIC Study. *Inflamm Bowel Dis* 2016; 22: 345-354 [PMID: 26717318 DOI: 10.1097/MIB.0000000000000638]

15 Levine A, Sigall Boneh R, Wine E. Evolving role of diet in the pathogenesis and treatment of inflammatory bowel diseases. *Gut* 2018; 67: 1726-1738 [PMID: 29777041 DOI: 10.1136/gutjnl-2017-315866]

16 Ahmad SY, Friell J, Mackay D. The Effects of Non-Nutritive Artificial Sweeteners, Aspartame and Sucralose, on the Gut Microbiome in Healthy Adults: Secondary Outcomes of a Randomized Double-Blinded Crossover Clinical Trial. *Nutrients* 2020; 12 [PMID: 33171968 DOI: 10.3390/nu12113408]

17 Ruiz-Ojeda FJ, Plaza-Díaz J, Sáez-Lara MJ, Gil A. Effects of Sweeteners on the Gut Microbiota: A Review of Experimental Studies and Clinical Trials. *Adv Nutr* 2019; 10: S31-S48 [PMID: 30721958 DOI: 10.1093/advances/nmy037]

18 Berntson L, Hedlund-Treatiger I, Alving K. Anti-inflammatory effect of exclusive enteral nutrition in patients with juvenile idiopathic arthritis. *Clin Exp Rheumatol* 2016; 34: 941-945 [PMID: 273383427 DOI: 10.1007/s10067-014-2672-5]

19 Ferguson LR, Smith BG, James BJ. Combining nutrition, food science and engineering in developing solutions to Inflammatory bowel diseases—omega-3 polyunsaturated fatty acids as an example. *Food Funct* 2010; 1: 60-72 [PMID: 21776456 DOI: 10.1039/c0fo00057d]

20 Levine A, Wine E. Effects of enteral nutrition on Crohn’s disease: clues to the impact of diet on disease pathogenesis. *Inflamm Bowel Dis* 2013; 19: 1322-1329 [PMID: 23399738 DOI: 10.1097/MIB.0b013e3182802acc]
