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Dietary practices, beliefs, and behaviours among adults with inflammatory bowel disease in Ireland: a cross-sectional study

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Inflammatory Bowel Disease (IBD) comprised of Crohn's Disease (CD) and Ulcerative Colitis (UC) affects 6.8 million people globally[(1)]. It is characterised by chronic relapsing inflammation which typically results in gastrointestinal discomfort such as diarrhoea, abdominal pain, bleeding, anaemia, and weight loss[(1,2)]. There are a range of risk factors thought to trigger the development of IBD, from genetics to environmental factors including diet. IBD patients often present with nutritional deficiencies, however, there are no gold standard dietary interventions for IBD treatment and management. Health care professionals use the best available advice when providing dietary recommendations, but patients often self-manage which can sometimes result in unnecessary food restrictions, and lead to further complications[(3,4)]. The aim of this study was to investigate the dietary practices, beliefs, and behaviours of adults with IBD in Ireland.

An online questionnaire was adapted for the Irish context to explore the dietary practices, beliefs and behaviours of people living with IBD, and to identify any dietary modifications made due to their IBD[(3)]. Ethical approval was obtained from the Research Ethics Committee in Athlone Institute of Technology. Statistical analysis was carried out using IBM SPSS Version 27.

In total, 484 adults (female n = 362, male n = 122) took part in the study with 61% of participants having CD and 37% UC. The mean duration since diagnosis of disease was 11 years. Ninety-two percent of participants were taking medication(s) to manage their IBD. Biologics (55.4%) and oral 5-ASA's (30.1%) were most commonly reported. Only 99 participants (20%) thought diet was a contributing factor to the development of IBD. However, 82% had modified their diet since diagnosis and 90% imposed dietary restrictions in the hope of preventing a relapse. The most reported foods avoided included fatty foods (80%), spicy foods (75%), and raw vegetables (68%). Sixty-four percent reported that certain foods, predominately low fibre white plain foods (74%) improved symptoms during a relapse. Most participants (84%) stated that their IBD affected appetite and pleasure in eating and on a scale of 1–10 (1 = no appetite, 10 = normal appetite), mean score for outside disease relapse was 8.36 (SD = 1.95) and during relapse was 3.71 (SD = 2.32). The mean difference between the two scores was 4.64 (SD = 2.54; 95% CI, 4.4–4.8; $P < 0.001$). Most of the participants (73%) avoided the same menu as others living with them to prevent a relapse and 56% avoided eating out for fear of causing a relapse. Additionally, 70% avoided food or drink that they liked to prevent a relapse.

These findings provide important insights into the dietary practices, beliefs, and behaviours of adults with IBD. It evident that for many adults with IBD diet plays an important role and our findings reiterate the importance of patient education and support.

References

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