Ensuring SIBO Breath Test Results Match Clinician Clinical Impressions Transcript

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Introduction to SIBO

Hey everybody, Dr. Rob here. I'm excited because we're going to talk about small intestinal bacteria overgrowth. And we've got an expert, the founder of Aerodiagnostics, Mr.

Gary Stapleton. Garry, how are you doing today? Very good. Thank you for inviting me. Looking forward to it. where there's an abnormal increase in the number of bacteria or the wrong type of bacterial in a small intestine, leading to digestive issues like gas bloating, diarrhea, pain, and malabsorption of nutrients, because the small bowel normally has fewer bacteria than the large intestine.

So most people have to realize that when they take these probiotics to populate bacteria, they're doing it for the larger intestine and not the smaller intestine That said, give me some of the causes of small intestinal bacterial overgrowth.

So it could be from food poisoning. It can be Yeah, pretty much it's gonna be in that realm, right? That's where we're gonna have it. But it can also be from malnutrition like you're talking about.

So you can create a situation where there's an environment for bacteria to grow. Unfortunate bacteria grow, so let's start with the factoid of SIBO. Did you know that if you have SIBo, small intestinal bacterial overgrowth, an over growth of bacteria in your small intestine, you could have leaky gut.

Leaky got does not necessarily mean that you'll have small testinal bacteria overgrow. Correct, absolutely. Now there's a prevalence of small intestinal bacteria overgrowth in the general population.

The numbers vary, but they're up to 22 percent. Prevalence in IBS is 31 to 55 percent, highest in a diarrhea predominant Ibs. Post-COVID I BS is 93 percent liver disease cirrhosis 41 percent fatty liver 35 percent Neurological disorders, my goodness.

Causes, Symptoms, and Prevalence

Parkinson's 46%. Alzheimer's 49%. Multiple sclerosis 38%. Metabolic conditions, diabetes 29%. My goodness, socebo is a full body attack. Absolutely. And some of the data that I've found, so not to contradict, but to add to it, is IBS suffers 82% for Ibs suffers.

I haven't updated on the worldwide population, we know that it's more than 4% of worldwide populations. It's prevalent, why are these numbers underestimated?

Well, I think primarily because the diagnosing of SIBO isn't as good as it should or could be. So you have patients that will have an infection in their small intestine.

So when you do that, you're uncomfortable. What do you? Do you self treat, right? You're going to take Tums. You can take this to do. That then when that fails, what do?

They'll maybe throw you some antibiotics or, you know, tell you to stop eating this food or that food. Then you get kicked up to a GI. Same things. I fax in this or.

That then you find a functional integrative naturopathic, maybe a medical doctor who's really been in tune with SIBO. So to answer your question short.

I just think it's underdiagnosed and undertreated. And certainly not, you know, they haven't used the correct type of testing to help in that diagnosis.

Well, let's do some of the clinical presentations of SIBA. Weight loss, stinky poop, vitamin deficiencies, abdominal pain. The big one is the food baby.

Baboop, baboop. Absolutely. How about the non GI ones? the rosacea, restless leg syndrome, joint pain. So let's dig in. You know, you're a specialist in testing.

What test do you recommend? So right now I've been in diagnostics my whole career, health care, my own career. My daughter was dealing with SIBO when I was living in Boston and we were told to go to the Brigham, go down into the thing in the middle of the day when you have to prep, prior to doing this with a 12 year old girl.

I knew we weren't going to get any usable data. It's just not good testing. I founded the laboratory to be accurate and be more convenient for patients.

The type of testing we do is SIBO breath testing, but also lactose, fructose and sucrose intolerances. H. Pylori wants you to do this. I wanted to specialize in doing this type of work to be sure that we got it right.

And the way you get it, right is matching clinical impressions of a patient to gas data. If the gas state is accurate, it has to 100% because we don't produce hydrogen or methane gases in our bodies.

It comes out of our body's when bacteria or Archaea is eating something. And if you prep correctly and you use the right kit, a very close capture kit and the laboratory does what they're supposed to do, now you have actual real data that you can interpret.

Then it comes into interpretation and that's the Wild West also. Different people are interpreting different things. So you mentioned substrates. You mentioned glucose, fructose, laculose.

The reason you used a carbohydrate is doesn't it ferment with the bacteria? Yeah, so our bodies, like I said, don't produce hydrogen or methane gas. So how do we know if we have an infection?

If you prep, the prep is 24 hours. And that's one of the most crucial things. A lot of labs don' understand that. They say eat highly fermentable foods.

I mean, I barely understand. We say the first 12 hours, chicken, fish, turkey, eggs, white rice, and white bread, followed by a 12-hour fast, typically overnight, so that when you wake up in the morning, you can begin collecting your breath specimens.

Breath Testing Basics and Prep

So that's how we get no food in GI tractors, to your point earlier. The small intestine isn't sterile, but it's nearly steriled. They call it less than 10 to the one colony forming units of bacteria, whereas the large intestine or colon has more than ten to 12, a lot of bacterium.

So if you're if your patient listening to this podcast, You have your mouth, your throat, you're stomach. And then there's a 23 foot tube. If you've ever seen anatomy, it looks like a bowl of spaghetti.

That 23 plus foot two is a small intestine. Then it goes into your colon and then food exits your body. So if you do the 24 hour prep, there is no bacteria.

I mean, no food in the stomach, small intestines or large intestines. When you did your first breath sample, that's the baseline. Why do we have you to do that?

Because we're not with you during prep. We need to make sure that you prepped. So when you do that baseline you should have very low gases and then you drink either, to your point earlier, glucose, lactulose, or some are using fructose now.

That becomes a food source that goes through all that GI tract. As it's going through that 23 plus foot of small intestine, if it finds bacteria, the bacteria has no choice but to eat it.

And when it eats it, it ferments it. It's like something rotting. When it rots, what happens? Gases come out, right? So these are hydrogen and methane gases that diffuse through the blood and exits via your lung air.

So if everyone does what they're supposed to do the right way, It's almost 100% that you're gonna have, if you have gas at a certain level, we know that there's too much bacteria where it doesn't belong.

So now we can treat that, and then we retest to be sure that it's gone. That's another big problem. And I'm not saying this because I own a lab. Use any lab you want, as long as they're a good one.

But you to retests, because you the weed and the root. You pull that weed, you a patient that's been suffering for a long time, whether it be diarrhea, constipation, bloating.

Let's say the diarrhea goes away. That's the whole thing that was important to them, right? They're still bloated and they're like, ah, that's just the way that I am.

No. And if there's still bacteria there, it's going to repopulate. and that where you hear people saying, oh, I've got the SIBO again. It's an infection.

All we need to do is get rid of the infection Well, you bring up a really good point. SIBO has a high recurrence rate, and I believe the recurrent rate is because people never really ameliorated the issue.

Absolutely. To recap what you said about SIBo, bacteria in the small intestine digest carbs and converts them into gas and short-chain fatty acids. More bacteria, more gas, or byproducts typically resulting in diarrhea.

Bacteria in the small intestine consumes what's meant for the organism, us, protein, vitamin B12, bile salts. This all leads to poor digestion of fats, nutrients, especially calcium and fat soluble vitamins.

And look at those stats that we talked about before. My goodness, if you have SIBO, it is a full body attack on our overall health. So the test, you covered the idea of preparation, and that's important.

Many of the people take a test. There's no preparation. It's not a hard prep. Done it. No big deal. it's Not like a colonoscopy, which is kind of like uncomfortable, if you will.

So let's get into the details of a task. Tell me what the difference between an accuracy if your comfortable with glucose. Fructose and laculose because you know that lacu Lowe's and glucose are Democrats and Republicans is going to be an argument.

Absolutely. And thanks for this question because it's so incredibly important. I like to say it this way that The glucose and lactose are both highly accurate for detecting SIBO in a patient regardless.

They just are. I've proven it time and time again and I was talking with you prior to this and i was saying how I even offered a few SIBO thought leaders to test a glucose and a lactose for five patients and that they can blind it and they could, you know, do it.

An informal kind of study to show that if you had a patient do glucose in a Lactose, they were both going to come back either positive or both gonna come either negative.

Never were they conflicting with each other. So my opinion, They're both very accurate. Now fructose can be accurate too. And we know that's mainly from the work of Dr.

Jason Horlick, right? But here's an interesting thing. I am the only lab, and I've done this since day one. If you were to do an intolerance breath test of lactose, fructose or sucrose breath tests with me, you're gonna get an answer,

positive or negative, right?

It's suspected or not suspected, because we don't say positive of negative. Only your clinician can make a diagnosis. We're an aid to that decision. But if you are to an do intolerant test, Think about the difference between an intolerance test and a SIBO test.

With SIBo tests, they're both three hours, by the way, intolerances and SIbo tests. Three hour breath collections. A SIBOTest, we're looking for gas early.

Why? Because if you think about it, remember we removed all food. Now you're going to drink either glucose or lactose and it's going go through. If it finds bacteria, in the first two hours, then we know that that gas is from the small intestine, not from colon, right?

With an intolerance test, we don't want gas early. We want late to be a positive indication. Why? Because if you drank fructose, lactose or sucrose and your body didn't have the ability to process that, it would go through that 23 feet of small intestine then would end up in the colon where there is and should be bacteria.

And so that'll tell us that you lack the ability to break down that sugar. So we are the only lab that I know of that has always reported that. If we get a lactose fructose or sucrose result and there's early gas, that being under two hours, at a certain level, and this is scientifically proven.

So we footnote with the scientific data that this more indicative of SIBO than it is of an intolerance. Now, if you have another elevation at the end of the test, then it's SIBo and the intolerant.

Interpreting SIBO Breath Tests

Yeah, I'm not trying to cut you off on that. I mean, that's a great take away and it's very unique is to test. And that is why I utilize your test so for glucose.

If somebody has a problem with SIBO and glucose lights you up, it is usually in the first 90 minutes. OK, North American consensus says 90 and I just disagree with not looking at the 1st 2 hours.

Tell you why. How many of you that are listening and or treating patients? How Patients have you had that you've experienced delayed transit, especially with constipated patients.

You cut it off at 90, guess what's gonna happen? You're gonna get a false negative, right? I can't tell you how many time we have distal positives. Let me tell what a disto positive is.

you're going to get three hours of data and a distill positive on my test is the data point that's either 100 or 120 minutes. So that's past the 90 that you just mentioned, right?

So what do I do? I could just report that because I know I feel confident with it, but I don't. I report it as a positive, then we pick up the phone and we actually call the clinician.

We say, this is distally positive. If you have a patient with faster transit, This could be the lactulose going into the colon. or the glucose going into the colon, right?

So I still want to report on it. And why is it so important to know that about the patient? Because we don't want give off a false negative. There are a lot of reasons why you could have a distal positive.

Let me give you one example. Compromised ileocecal valves. For those of you that don t know, that's the doorway between the small and the large intestine.

It's a flap. If it is stuck open or partially open, what happens? All of that bacteria in the colon creeps up into the distal small bowel. But if you were cutting it off at 90, you're losing that.

You're loosing that just because you are going to make this opinion that 90 is it. I say you look at the first full 120 minutes. And then you challenge those that are only positive 100 or 120. Outstanding.

Let's do a little rapid fire. I'm going to put your feet on the calls. All right. Accurate, inaccurate, substrate, glucose. By the data, it's more accurate than lactulose.

However, I think both are extraordinarily accurate. In my opinion, I wouldn't say you have to use glucose. I would say both are highly accurate. It's all about the interpretation.

Got it. Fructose. Very accurate, Jason's work, Dr. Horlick's, work is fantastic, but we've always reported on it, so I don't disagree. The only thing with some of that work.

Is people want to. Use more than once they want. To order a fructose, a lactose and a glucose and patients just can't afford it That's a lot going on.

So open-ended question, fructose works which part of the intestine? Glucose, works, which body intestine for fermentation and lactose? Which part? Let's have some clarity on that.

Yeah. It's just the food source. If you removed all food from your GI tract, right and your small intestine is supposed to be not sterile but nearly steril so when you eat that food source it's going to feed bacteria if it is there and that's what's gonna present the gas now some why so then why not just use those right why do we even talk about lactose or glucose because they haven't been validated for this and do they truly feed the broader base?

Jason's work suggests that fructose, you know, feeds a broader based of bacteria. But the good news here, the Good News here is if you do all those things that I've repeatedly talked about here on this, You're going to get this 100% of the time, unless you're one of those one to 2% patients, in my opinion, that for whatever reason, The bacteria in your body is producing hydrogen sulfide gas.

And if so, You're not, you may not see that on a hydrogen and methane test. So how do we know that? With lactulose, sometimes you don't get, with lactules, even a negative test will have a bolus of gas in the last three test tubes.

That's when the lactose enters the colon, right? Even with glucose, it enters, the column you see a little bit there, but not as much as lactolose. Right?

But the, so if you, don' have that rise of, gas, or if, your doing a glucose test and the gas levels are all really low, like one, two, zero, is that kind of thing?

We, again, do a really interesting thing. We pick up the phone and we call the clinician. If it's glucose and it is really low, I say, you know what, it really is low gases here.

Number one, make sure that the patient drank the glucose. You would be surprised. How many don't do that? And then if it was lactulose and you don t have it, then I want to ask questions.

So I have a document that I send out that are nine questions, Did they drink the lactulose? Did the mix it with water? did they have a colonic recently?

Do they a virus? I had to add that one. And then, and I want to thank Dr. Seebecker for these, that there are five questions that you always should ask a patient because that'll tell tail sign of hydrogen sulfide and that's peripheral neuropathy, so tingling numbness, hands or feet.

interstitial cystitis so burning urination bladder irritation issues with lighter noise fibromyalgia so body pain body ache and then to your point earlier it's the flagellants or the gas that smells terrible it smells like a riverbed or rotten egg odor that's sulfur gas so if you have those and you still could have hydrogen or methane gas production but maybe you're one of those one or two percent that only produce that so This is why we don't test for hydrogen

sulfide because in my opinion, it cannot be done accurately because hydrogen sulphide degrades very fast.

So if you had your person and you have right at the machine and he blew over a sensor, you could register it, right? But if your sending it somewhere, or if any time lags it degrade very quickly.

That's why don t test it currently because I don' t want to give out bad data. But, if Chronic postprandial SIBO symptoms like bloating, cramping, nausea, joint pain, restless leg syndrome, rosacea.

Any of those. Diarrhea, constipation. And you have a positive on the test. Then we know if you. Have a negative and it's really low gas or with lactulose, no gas at the end.

You want to ask those five sulfur questions. If you get a. Positive, you'll actually treat differently according to some SIBOTHOLT leaders like Allison.

where you'll either use bismuth alone or you use it in combination with your antibiotics or your herbal antimicrobials. Now, me and the lab, that's not my point to tell you how to treat.

That's what clinicians like Silverman do here and they're best to guide you. We're the best that guide to get an accurate data so they can make a right decision.

Right, you're trying to give us the data so we can have a protocol. So one data that we really haven't gone through, I mentioned it before, is the methane in the hydrogen.

The methane implies… What, hydrogen implies what with the patient? Think of it like this, right? We shouldn't have methane or hydrogen production in the first two hours because that's the way we're supposed to operate.

But when you have an infection and we do get this gas, think about the approaches to treatment are step one is if you're positive for hydrogen, your choices are antibiotics.

herbal antimicrobials or elemental diet. If you're going to use antibiotics, you are going use a single antibiotic. Many like Xifaxin because it stays in the gut.

The problem is the pricing. They jacked the price when it was bought by that pharmaceutical conglomerate. But guess what? 2030 is coming. That's when goes off patent.

And then elemental diets. You have that. When methane is part of the story, so now if you're positive for hydrogen and methane, that's when treatment approaches start to change.

Methane, Hydrogen, and Sulfur Patterns

With antibiotics, it's not a single antibiotic anymore, combination antibiotics, like the Xifaxin Neomycin or the Zifoxin Flagell. Why? Because with methane-positive SIBO, there are great studies out there that show if you use Xifexin alone, when there's methane present, you're only 33% likely to eradicate the bacteria versus the xifacin neo or flagella.

You increase it from 33 percent to 87 percent. So you want combination antibodies. If you are using herbals, You don't want to do just your normal, you know, burberry, neem, oregano.

You need that whole garlic and it's not food grade garlic. It's a medicinal garlic, so you use that to attack the methane. With elemental diet, there's no change.

So that's the difference. That's how you treat. And then if you're dealing with sulfur, then that's when you would get into the compounded bismuth, like sub-citrate, subnitrate.

Not pepto-bismol off the shelf, that kind of thing. So some factors which protect against SIBO. I'm going to list them

for you. They protect. Obviously, if they're aberrant, they cause SIBo.

Gastric acidity, pancreatic and biliary secretions, bile. the hidden gem probably in functional medicine. You call some immune system, gut, your gut permeability or increased intestinal permeabilty.

The migrating motor complex, peristalsic wave-like contractions that move food bolus from the stomach small to the large intestine, it's that cleansing.

And you mentioned it, ileocecal valve. They flap between the small and the large intestine. If it gets locked or stuck open or closed, it's a great cause for SIBO.

And maybe the biggest thing that we'd like to talk about, vagus nerve. Nerve number 10, your rest and digest nerve, So they don't miss anything. No, but that was very complete.

Thank you. But let me go back to that slow migrating motor complex. So should they or may not? No. That's the action that moves food through that 23 plus feet of small intestine.

Think of it almost like a snake or a caterpillar, right? It's moving things through. And when that's compromised, what happens? The food just sits there.

Ferments. What you're speaking to is it starts to rot and starts the ferment. So when we report out results, if we have elevated and sustained levels of gas, which as defined by 10 parts per million or more of one or both gases all the way through the small intestine, sometimes you don't even get to the rise of guests and a test will say not suspected.

but we put the footnote that you have elevated and sustained levels of gas. It can and certainly is a positive as long as the patient followed the prep correctly.

That's the only way you can get elevated in sustained is if you've slow migrating motor complex or that they didn't prep properly. So we've put it as not suspected, but then we footnoted, elevated, and sustain, certainly an indication of a positively.

And then, we call the clinician and say, hey, don't miss that foot note because this is important. It's important to know that you're not only going to use your antibiotics, herbals, or elements, you can have to get a prokinetic at some point on board to be sure that your addressing that.

Because if you don't address that and just kill off the bacteria, it's likely that the same thing is just going happen again. So what I like that, I should really use a stronger word than like, what really imbues me with enthusiasm to your test is the fact that you work with the clinician and with all the years of experience and tests.

But I'm a chiropractor, so I want to talk about SIBO causing spinal pain. So number one, SIBOL can cause inflammation because toxins produced by bacteria in the small intestine can causes inflammation in a spine.

Number two, die-off symptoms. Let's talk a little bit about that. When a body eliminates endotoxins produced dying bacteria that hurts reaction, it can cause a temporary increase in inflammation in the spine.

So those chiropractors, naturopaths, osteopaths orthopedics, maybe they should start looking at that gut to spine axis. The floor is now yours. One of my largest groups that use me are chiropractors absolutely across the world because I work in 42 plus countries and I will tell you that these patients are ending up in your office not only chiropractors but dietitians naturopathic physicians functional medicine that's where they're ending up because much of the time not all of time certainly they are failing at primary GI or otherwise and that is not to throw a stick at GIs or primary not at all it's just I see it, I just see every day and to make a point on, you know, the combination.

I don't think you can do this work if you're not having conversations with the clients. Agree with you. You're just throwing mud at the wall. That's what we do all day long.

I'm going to add a little legs to the conversation, Gary. I want to talk about SIBO neurological problems, vitamin deficiencies, D-lactate acidosis, brain fog, central nervous system diseases, headaches, fibromyalgia, vagus nerve dysfunction, peripheral neuropathy, and histamine levels, which is a whole other tundra.

And I don't think we want that rabbit hole. But people have to realize that they need to test and need use accurate tests for small intestinal bacterial overgrowth.

So this really leads me to the next frontier. How do you differentiate SIBO from leaky gut? Well, with leakey gut, the problem is false negatives. Why think about it if you're if your small intestine is like one of those soaker hoses has a bunch of holes in it, right?

Treatment Approaches and Recurrence

So if if You're eating or drinking the excuse me drinking The glucose or the lactulose and if have severe leaky gut and it's leaking out very proximal and you may have a distal infection then you know, are we is that the issue is, that we're getting a false negative because the substrate's not getting through all 23 plus feet.

So it's very important to understand if you're dealing with a leaky gut patient, we have to be sure that they're, getting all of that substrate down to know for sure if we are dealing Seabow or not.

But yeah, there's a high correlation between the two. Why? Because if have an infection where it doesn't belong in your small intestine, It's creating a bad environment for that small intestine.

So that's how, a lot of times, leaky gut comes about. You know, it's funny. For leakey gut, we use a lotta probiotics. They used to say you couldn't use the probiotic for SIBO.

That was wrong. Now, for leaky got, you use pre-improbiotics. Where do you stand on prebiotic for small intestinal bacterial overgrowth? Well, I think that there's been there has been a lot of success with both with these clients depends on the client.

I mean on patient, right? What's going on with that patient? Right? Is it is it a you know flat out everyone should be on them? I don't think so. We have to take each individual and say is this appropriate for them.

So I'm going to ask you a question about the test. We've talked about this off camera. Why is sensitivity and specificity not regularly used when discussing breath testing?

Yeah, I think that that's the case. And I make that case because when these sensitivity in specificities studies were done, they're not doing them anymore.

Money's not there to do these kind of studies now. But when they did them, the patients weren't in a closed environment. It wasn't like you brought 50 or 100 patients into your office or a hotel and said, OK, I just want to see you can eat from these foods.

Here you go. Eat just these food. And then after this, we take all the food away and it's just water. And then, so prep, how do we know these patients were at home?

So was prep done correctly, number one. Number two, did they use a closed capture kit? What is a close capture kid? It's when you provide your breath sample, is it never opened up to room air.

You have labs that it's opened the room. They use screw top test tubes and a paper straw and they put it, they tell them, take the top off, put down, paper, straw in and blow.

in a 10cc test tube, right? And then take the cap and put it back on. So my point is, we need to be sure that prep was accurate, that the devices were accurate.

And like our machines, the manufacturer says, let's calibrate them, make sure they're reading correctly. Every hundred patient tests, we do it every five patient test.

If you were to walk through our lab, five trays, four blue ones and a red one. The red ones, they have to calibrate the machine. We have cameras over above the machines to make sure they're doing it.

And then it comes to interpretation. So back to the sensitivity and specificity, if you're interpreting different ways, as an example, I don't use the North American consensus.

We've talked about many reasons why. One, they talk about measuring the hydrogen and methane from baseline. You don' t do that. It's the largest rise in the small intestine.

The other bigger one for me is 10 parts per million anywhere on the test for methane. If I were to rerun all 100 plus thousand tests that I've run with that as a new filter, I'd have 60% more positives.

It's unrealistic in my opinion to say that 10 parts per million in the colon is an infection. I just don't agree. I don t think the work's there. There's some good work out of some of the sites, but we need more sites doing this work to be sure.

Not just one in the United States. We need some sites to tell me, and you, that 10 parts per million in a colon is a positive. So give me three things that people should avoid in the C-Ball test and then on the converse, give three that are critical for the c-ball test.

So three to avoid are, it sounds like a broken record, but you have to have instructions that Good about the prep and that's why our customer service team there in touch with the patients they're on a call list minute they get the order there on the call is to call the patient how can we help you understand not only have a clutch your breath but how to prep.

And then use the kit the kids we buy our kids. Because they're very expensive, but that's how you get the accuracy. And then, of course, the interpretation.

So avoid where the kits aren't closed capture. Avoid poor prep. as I was just talking about. And then it's the exact opposite side.

Gut Motility, Leaky Gut, and Related Conditions

Have good prep, have good kits, and use a good interpretation. This is actually pretty good. I think you'll like this one. When I speak to interpretation, I say there are four general approaches that I'm aware of.

Number one is Dr. Lyle Hamilton, who invented this whole thing, right? back in the 70s. That was the basis for the Rome consensus. Then you have the North American consensus, which I don't favor, but I can interpret through the north American lens if someone wanted to use my lab and say, no, I want the northern American.

Fine, we can do that. But the fourth one is the best one, and it's throw out everyone else's opinion and let's just look at the data and talk about the patient.

Do we have a good baseline? Yeah, do we? Have good CO2? Yes, Do. We have gas in that first two hours? When a 20 is the magical number, it's just Venn diagrams, right?

Are you going to say that's not positive if you have a patient sitting in front of you with chronic post-perennial SIBO symptoms and we got a rise of 19? No.

Matter of fact, when we're close like that, because I know clinicians are so busy and they get these reports of positive or negative or suspected, not suspected.

If I got to rise at 19 or 11 for Methane. I'm calling. We're calling that. And you're saying, it says not suspected, but look at this. Look at where it's says here.

If your patient has chronic symptoms, you might still want to treat. So I want talk a little bit about the FODMAP diet. FodMap is obviously an acronym.

Fermentable, for F. O, ogleosaccharides. D, disacchorides, M, monosacharides A, and, P, polyols. is the hardest diet for patients to comply with that I've ever used.

However, if they're able to comply, it's magic. Do you have any feedback on that? I would, I do. I agree wholeheartedly with your comment. The only thing that i want to emphasize is, the FODMAP diet is not going to eradicate SIBO.

It's incredibly important, but that's not going to eradicate SIBO. So, you know, keep that in mind. I have this really quick little story about the whole ileocecal valve issue, the cause of SIBo, and it just popped into my mind, had this client in the UK.

She was positive, positive positive. Always at the distal end. And so I kept calling the clinician, hey, I think you got an ileocicle valve. You may want to send her this oral massage.

Time goes by all of a sudden. I get it. The client calls me says the wife and the husband want to talk to you. They're very upset Okay, so I got on the phone and she says I don't know you just sent me a negative test and And I wasn't even treating I was like first.

Let me ask you did you How are you feeling? Oh, I've never felt better. She goes, but I didn't treat I I know, but what did you do? So after all those rounds of antibiotics and all the things that she was doing, when we called about the ileocecal valve and she went to visceral massage, she fixed it and the body took care of the problem.

So you don't always need to do it. Sometimes it is. But that's why it's so important to look at this data and treat it as such, not just say positive or negative and here's some diet or here are some antibiotics.

Yeah, we treat patients. We don't necessarily treat tests, but we need qualified, accurate tests to direct us in the right way to treat the patient. One little aside, I may have been amiss.

When the vagus nerve tone is down, that's when the migrating motor complex and the iliocicular valve are aberrant. Just want to make that point. In addition to that, you know, it's interesting.

It's been mentioned that we use antibiotics for SIBO, but antibiotics have a very deleterious effect on the gut epithelial layer, i.e. causing leaky gut.

So is it fair to say one of the biggest components of SIBo causing increased intestinal permeability is the fact that they use a lot of antibiotics? Not saying it's wrong, just saying that's one the downstream effects.

Listen, if you could avoid using them, who would not want to? Sure. We just, you know, If you can avoid it, it would be great. But it's unfortunate with some of these cases, not unfortunate.

It works, but it has these other effects. You can't argue it. Right. My buddy's watching from Geneva and I always like to end. He always wants something.

So give him three things he now needs to know about SIBO because he's on this health journey and he is doing great number one. When a patient presents, it has to be chronic, postprandial, after food ingestion, SIBO symptoms.

SIBo can look like a lot of things, mold, fungal, Lyme, parasites. Before we throw everyone in the SIbo bucket, let's make sure the clinical is there.

It has be to chronic. That's the most important thing. So it doesn't matter if it's Monday, Wednesday, Friday.

Testing Access and Final Takeaways

Doesn't it matter this food or that food. Some highly fermentable foods, they'll feel a little bit more intense, but you're going to have the symptoms chronic.

If you are not quite sure, then you test to confirm that you aren't. But most clinicians are testing to prove their suspicion of the infection. Cool. Absolutely great.

So Gary, before we part, let them know where they can get the SIBO test. Well, thanks. They can call Aerodiagnostics and our website has the phone. It's obviously www then aerodiagnostics.com and that's spelled A-E-R-O diagnostics dot com.

And then the numbers are there. So simple call or an email to us. We set you up. There's no charge to set up in our systems and then we do accept insurance.

Where a Medicare provider and we have I think the most aggressive pricing out there, meaning we're toward the lower end of all the labs that are doing the work, but we have we send out kits, we get an order, We send our kits UPS today comes with a two day label to get it back to us.

We have a 24 hour turnaround time. Great. And if you have, if your elemental diet patient, we do it even faster. You just let us know that they're inbound and we'll turn it around in an hour so that we can determine whether or not you stay on the elemental Diet or whether you now can return to, you know, regular food.

Terrific. I believe I'm going to proclaim right now. that SIBO will be the conversation in five years what leaky gut is today. We've been talking about the gut and well, we should, but part of the guy being the epicenter of your health is not having small intestinal bacterial overgrowth.

You've got to do this again. we could have been here for hours upon end. And I mean, it's a really deep, sexy topic. I thank you for your time, Mr. Gary Stapleton, Aero Diagnostics, Dr.

Rob Silverman, Proven Health Alternatives.