Hey, everybody. Great to be with you. I have a special treat for you. I have Doctor Pratha, an integrative gastroenterologist. Very special person. Special doctor.

There's not many of them out there. We need a lot more. And she's helping a lot of people. So we're going to get her insights today. On how she looks at inflammatory bowel disease, Crohn's disease, ulcerative colitis.

And if you have those conditions, you know, that can be very involved. But she's going to help us break this down and understand how to approach this with integrative medicine.

So Doctor Pratha, great to be with you. Thank you. Likewise, doctor. When medicine we have the patience with acid reflux and irritable bowel syndrome and indigestion, all sorts of things.

The inflammatory bowel disease. These people are helped a lot with natural medicine and integrative. But it definitely can be more complex. You know, from my viewpoint it's it's you got to know what you're doing and it can be a more these can be obviously much more serious condition.

So give us your thoughts on what's going on with inflammatory bowel disease. I know you have a lot of experience with it, maybe from a Western model and then from an integrative model, if you would. Yes.

Actually, one of my biggest passions in the field of gastroenterology is in planetary boundaries. And nowhere is there a need for somebody with my expertise then in this space, as you just said, it's really much, much more complex for the average alternate health care practitioner who has an experience in dealing more with wellness.

And these patients clearly have organic disease. They have classic, symptoms that are often, you know, associated with significant damage within the gut if it's myths.

And so most of these patients need the care of a gastroenterologist. And most gastroenterologists out there have a lot of options, a lot more options than they ever had before with inflammatory bowel disease.

But most of them are not interested in the subtle symptoms that some of these patients display that cannot be fixed by using the medications we have in the basket.

So for those of your patients, for those of you people who are watching the segment, inflammatory bowel disease, as you said, is a spectrum. We have two common conditions that come under that spectrum called ulcerative colitis, which is an inflammation that is generally localized to the colon and involves the entire colon versus Crohn's disease, which is a similar disease, but different.

That affects the entire gut, literally from the mouth all the way down to the anus. And both of these can be associated with what we call extra intestinal manifestations, where patients who have inflammatory bowel disease can have arthritis, they can have skin conditions, they can have other organs being affected, like the eyes and the liver and a whole bunch of other parts of the body that can be affected with inflammatory bowel disease and what we call extreme inflammatory bowel disease.

So all of that falls within the spectrum of what can happen. But I guess the underlying condition that defines why you have a kaleidoscope disease is really that there is quite a bit of inflammation within the gut.

So it's considered both of them are considered autoimmune conditions where the body's immune system is dysfunctional and is actually destroying itself, which is the bottom line of all our immune anyways.

So the body is generating antibodies to different parts of the of the gut, and that process of the antibody production and all the chemicals that are drawn to that site as a result of that immune system getting activated, results in

destruction, which can cause everything from my rousers to creators of ulcers to fistulas, to abscesses to pretty significant pathology as far as organ damage itself goes.

And this is why, you know, gastroenterologist with that background is important because, you know, serious things can happen if the person, the patient is not doing well.

So do you find I probably presume, well, these patients come to see you there on medication or they need to be on medication period of time. Then you're working with the natural treatments to kind of reverse change underlying environment.

You know, the reasons for the inflammation. Tell us about that process. Yes. So from a Western model, the way we approach inflammatory bowel disease is obviously we're trying to control the damage.

It's very similar to our to a forest fire that happens in like a Southern California fire. And I often think, you know, I tell patients it's kind of like, you know, a lot of these patients are smoldering.

And if you don't stay on top of what's happening, then you could have a full blown fire on your hands. And then it's impossible to put out because there's been so much damage happening so quickly that, you know, can never get ahead.

So you're absolutely right in what you said. That where I see the advantage of integrative medicine is I have, at least in my space, is that I have the ability to use the tools to stop the actual burning.

While I can then work on the reserve in the body and start to restore the body's natural functioning. Because the Western model only has options on how to control the limitation and how to take out the immune system at varying levels to help the body prevent itself from hurting itself.

And I don't mean take it out as and we don't. We're not doing exactly what chemotherapy does for that matter. You know, it's all levels, but it is immune modulation.

So the crux and cornerstone of Western therapies, immune modulation and immune suppression, where we're trying to bring down or dampen the body's immune response.

So there is not going to be as much inflammation. And and we have some miraculous drugs out there that work amazingly when it comes to actually controlling that and happen to kick in very fast and also have sustained benefits in terms of long term therapy with respect to maintaining the remission we garnered.

But there is no exit strategy. The problem is, if you go to the average gastroenterologist and and you ask them, you know, what should I do once I'm in remission?

And a lot of these people are young, as you know, I believe is a disease of the young, you know, so it actually hits patients in a bimodal distribution, which means the first speak of the disease onset is usually in the early teens or early adulthood, like in the 20s.

And then there's a second peak, you know, later on in life. But the patients who come to us often are very young. So the concept of needing a medication for the rest of your life, when that might be 50, 60, 70 years is a little bit of a tall order, in my opinion.

I mean, I'm somebody who can't even finish an antibiotic course. So, you know, I totally understand a patient's reluctance to say on medication. So a lot of patients who come to me, come to me, both for management of the acute disease as well as what else can I do to help myself so I don't have to keep taking these medications.

And that's a question that Western medicine asks naturally, because all these medications are very expensive. They cost the taxpayer a lot of money as well as the patient.

But there's no exit strategy. And the reason there is no exit strategy is because of this lack of understanding that there is you need to integrate and and repair the loss of natural reserve within the body that's creating this extreme state of dysfunction.

And until you restore it, you're not going to be able to let the patient to stand on their own. So the the herbs and supplements we use work in the background while the medication holds the front.

And so studies are being done on discontinuation like cancer. We we believe somebody to have had what we call a prolonged remission once they cross about five years of not having an acute player, then most doctors are willing to cut back.

But even then we're worried because when we do start to pull off, if we don't do the work alongside, then the patient runs the risk of a relapse. So that is a very real need.

And in the IBD world. Absolutely. Can you talk about and we talked about this series about leaky gut syndrome in terms of inflammatory bowel disease. Obviously, we always think of a lot of people think of leaky gut in a small testing.

And yeah, there is literature demonstrating that, of course we know that occurs in the colon two and inflammatory bowel disease. Give us your thoughts on that.

Well I think it's misunderstood because that is virtually everybody I know has a leaky gut, yourself and myself included. It is the cost we pay of living in a modern world.

The reality is the gut is supposed to be porous. It is like a sieve. It's supposed to absorb nutrients. And if it were like your skin that really didn't absorb a whole hell of a lot, then you know you would basically not be able to absorb.

You need chains as well. So I try to tell patients it's not as if it's unusual to have a naked gut. What is interesting is that, you know, with the leaky gut, you had big, bigger proteins getting through that shouldn't.

But you then have this tendency for those proteins triggering your immune system. That is the part that, you know, for a lot of people is predisposing to conditions like IBD.

And they have done studies, old studies where they've looked at family members with IBD and, you know, patients who had Crohn's and colitis when their first degree relatives were tested, they were seven times more likely to have a leaky gut and leaky gut, as measured in Western medicine, by actually using mannose or a large sugar and testing permeability of the gap.

When you looked at permeability studies, there was a, you know, much higher likelihood of family members who had no symptoms having permeability issues with the intestine.

Well, well, well, you know, higher than the average public would have. So leakage is a precursor or a predisposing situation that can antidote the diagnosis of IBD by decades often.

So most most people who had a predisposition for I'd have a childhood history of allergies, both food allergies you know asthma, eczema rhinitis I mean this is the prolog and that, you know, that patients displayed prior to evolving to IBD because there is a certain allergy personality type who has the underlying immune hyper reactivity.

And then when you throw in the lack of awareness about immune boosters, the commonest ones being all the vaccines out there, then you're playing with fire.

Because oftentimes what starts to happen is the patient's immune system is primed, and then all it takes is vaccinations or a major, you know, virus like Covid or, or Epstein-Barr or, just a bad case of shingles or chicken pox.

And suddenly you now have the patient having symptoms and destruction of the gut, where the immune system's now completely out of control. So there is definitely a linkage between Mickey Cat and inflammatory bowel disease.

When you actually have inflammatory bowel disease, it's no longer a leaky gut. You have a destroyed. You actually have holes in the intestine, you have ulcers, you have a complete breakdown of the lining of the patients.

So those patients, you don't say that anymore because at that point they already have within the gut. Yeah. What do you think about the theory of infectious disease is playing in inflammatory bowel disease.

I'm diagnosed parasites bacteria. This is this has talked a lot about in holistic medicine. I'm just curious to get your thoughts as a gastroenteritis or actually, you know, seeing the tests and you're going away from the theoretical to actually, you know, what the tests actually show.

Do you see that much or not so much? Well, are you talking about acute infections? Are you talking about the actual overall? It's like a trigger, like triggers, initial triggers.

Sure. As I talked about, you know, the tendency to have a leaky gut pre antidotes that the tendency to have a hyperactive immune system and the tendency to have different manipulations that have interfered with the microbiome, the microbiome development is a very, very key part.

It's it's as unique as your own fingerprint, the microbiome in your body. So the events, every event that has happened in your life prior to the manifestation of the infantry biologist has played a role in creating the disease.

So for patients who have had, let's say, a bad case of traveler's diarrhea or multiple episodes of food poisoning, or have had, for instance, any kind of systemic infection that required antibiotics in a heavy duty way line patients who've had any kind of chronic infections that are recurrent sinusitis, recurrent bronchitis, you've had multiple antibiotics.

All of these predispose to inflammatory bowel disease because you're self-selecting organisms that are far more resistant to the antibiotics and therefore are much more likely to be than the ordinary commences, or the normal population that you develop in your gut if you've had a relatively healthy childhood.

So in that regard, infections play a role. But interestingly, what you alluded to with parasites and certain parasites, of course, you know, same token, you know, if you have or if you have any biases or salmonella or Shigella, any of these acute infections that can destroy the gut will definitely predispose you to activate your immune system, which you need that immune system to actually fight this infection.

But then the problem that I believe is it's a dysfunctional immune system. Once it gets activated, it doesn't come down. So there is, you know, that tendency to predisposed to having a flare by or the actual onset of IBD after you've had a major that infection.

So that's what you were alluding to. But interestingly, there is this hygiene hypothesis also, which we had in Western medicine where we recognize that there is a disease of the developing world, a developed world.

It's not as prevalent in the developing world, where there is a tendency to have a higher incidence of infections, chronic parasitic infections like flukes and like tapeworms and roundworms and whip worms.

And so, you know, the immune system, the kind of T cells you tend to self-select out one versus T, h two tends to be the actual predisposing factor where you can have low, low lying, chronic inflammation that predisposes you to have a two type response that then brings down your overall hyper active Indian system.

So those countries there is less likelihood of IBD than for instance, in the developed world. So people have even used, you know, a whip worms where they've taken the eggs of pig whip worms and put them into patients with IBD.

And I've had a few patients who have had that done to them. And these worms live in the small intestine. They don't cause disease because they are not pathogenic to the human host, but they do dampen the immune system so that the patients, you know, slowly respond.

But as with everything else, you know, it's a spectrum. You know, everybody comes to this with a certain level of dysfunction that's unique to them. And then the level of treatment efficacy that they obtained from any intervention varies.

So like most trials in in any kind of chronic condition in IBD, it's hard to prove alternative therapies because patients are a mixed bag. They have varying levels of symptoms.

So so this particular therapy which was very, very promising kind of has gone nowhere because of, you know, it's not being as powerful, for instance, as one of the pharmaceuticals that has recently been approved.

What are some of the patterns you find you help patients with in terms of diet? A lot of practitioners find grains or problem. Tell us a bit more. Maybe what you find in terms of dietary patterns which seem to aggravate inflammatory bowel disease. Some of the most likely.

Tell us about that. Yeah, sure. Yeah. Diet is a very, very big part and I'm really happy to see, finally, after 30 years of me trying to do this, I've been doing this for 30 years.

Just in the last half a dozen years, I'm starting to see studies where they're now recognizing that, no, no, we have to work with the diet a little bit.

This is I'm talking about Western GI rather than integrative GI. So diet is a big deal. I find that antigenic foods in the diet are a big part of it. We talked about gluten and other conditions. Gluten is a big one.

There is a very, very big one, particularly in IBD. There is a big deal. I do recommend patients go on a very strict diet when they have active IBD. I don't subscribe to the traditional Western concept of diet where they say, oh, just bring down the fiber and then just eat a low residue diet, which would generally, by definition, be typical American diet anyways.

So most patients are very confused when they get, you know, orders from the regular doctor who says, oh, you can eat anything to just avoid any fiber and avoid anything that can scratch the internal lining of the gut.

And like no, fiber is not necessarily going to damage the lining of your gut. If you have a narrowing, if you have a stricture, or you have actually a blockage, anatomical blockage in the actual intestinal lumen or the opening in the intestine, then yes, of course you are bound to be on a low fiber diet.

But save that situation. Fiber is actually healthy, as you know, so that the most important thing is if the patient is not actively bleeding in an active player where it should not have more bowel movements, I encourage the fiber.

I often go back to, you know, the two dietary protocols that are really very helpful there, which is the specific carbohydrate diet. I'm sure you've heard of that and the Gaps diet.

I use both of them, which are very closely related. The gaps that I think a little bit more detail and stricter version of this SCD diet. But those are the two diets I often recommend to patients.

I use a lot of herbs and supplements, and I did. I work on the body's adaptation. The issue with anybody who has a chronic inflammatory condition is they don't do well with the adaptation.

There are mechanisms are heavily stressed. So, you know, working on the adrenals to support the adrenals working on their hormonal systems to support their both adrenal function as well as the pituitary organo axis functions, where we're working with the hypothalamus, the pituitary and these organ systems.

That's what I use in my herbs. My herbal formulations are all to regulate all of those things at a systemic level. And then of course, at a tissue level, I work on, you know, obviously the muscle herbs to support and promote that lining, to build the intestinal barrier to support digestive function, work on the liver.

So, yeah, the numerous targets that I use a lot of different things for. Absolutely. And so obviously when you treat these people within bowel disease as an integrative gastronomy, I presume in general you find much better results than just doing the Western model.

When you're doing the combination model, can you maybe just speak to that a little bit? Yes, absolutely. Oftentimes when I look at the traditional Western literature out there and I see, you know, the response rates, for instance, I'm not very impressed with response rates, even even even of the ones that are approved.

More recent additions, most of them have, you know, 30% if you talk about remission, where they actually heal the lining of the cat, we're talking 30%, which is 1 in 3 patients will have that response.

If you talk about clinical response, we're getting up to 60, 65%, which means at least 65% of patients are going to feel some improvement. When I use integrative therapy, my numbers are higher 8,090% because I'm actually I'm actually working with patients, supplementing their body and helping them heal.

So a lot of these patients have that. Then the other issue we run into with IBD, when you just use the Western model is loss of response. So patients seem to have an initial response and then they lose the response where you keep them on the drug and then they no longer work and they develop a fracture.

And then you're changing drugs. So this tendency they have to switch between classes or switch within the class for different products. And you know, what determines loss of response has been a confounding factor for a lot of, you know, gastroenterologists.

We we have studies where we're looking at drug levels increasingly to see if the drug level generation of antibodies, because these are big molecules.

So in a patient who has a dysfunctional immune system, they're going to develop antibodies to the medication we're giving, which is an antibiotic. So you're developing an antibody to an antibody which is human antibodies or what they're called is another issue we deal with.

And I find that all of these are being studied as determinants of loss of response, except they don't have conclusive evidence that that's what's happening because there are people who develop antibodies are still responding, and there are people who don't develop antibodies, who are not responding.

So so it's not as clear cut. And so lots of response is also much less likely in my patients. In other words, when I find a treatment that works, they are able to stay responsive for longer because they're doing all the other things that, you know, we're working with.

So so I don't have to switch between drugs as often as patients who are in a traditional restaurant practice end up doing so. These are the benefits. And then finally, the benefit is I have an exit strategy.

I mean, there are patients have gotten off medication, which, you know, is not something that most colleges do very well because they don't have any expertise in that area.

Yeah. That's good. And the cool thing is obviously not just with the patient signs of symptoms, but you can measure with your treatments objective markers like fecal cal protecting you can you can see the inflammation markers come down so you can verify your treatment is working even at that level.

So that's really neat. Yes, absolutely. I also do additional blood analysis as part of the antibiotic workup. We have another medical model we create.

So it's a patented software that was developed by the people who, you know, have brought into Biogen to us. And so I enter the blood blood tests to these models into this software that I had.

And I can actually look at hormone activity. I can quantitatively assess as well as quantitatively assess the actual shift in the biology of the human being.

And so changing the biology of the cells, I can actually predict whether they are likely of a flare before the flare happens and manage it, so on and so forth.

So, you know, there is a lot of objective evidence also that I use, as you said. Well, that's that's really good. Well, Doctor Pratha, thank you so much for your time and for people who want to get more information, doctor practice here in the San Diego area.

Just go to our website, integrative gi.com that's integrative the letters GI and then the letters SD like San Diego. So integrative gi SD com. So doctor Pratha thank you so much for your time and expertise.

We've had you on three different topics on this summit. And so we really appreciate your time. Thank you.