Inflammatory Bowel Disease (IBD) Causes, Risk Factors, Treatments And More Transcript

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Doctor Talks Introduction

Welcome to Doctor Talks, the podcast where every episode leads to a healthier you. Join us as we navigate the world of optimal health, uncovering groundbreaking strategies to conquer chronic disease.

In each episode, we'll bring you the latest insights from leading health experts, medical innovators, and wellness warriors. If you're seeking to transform your health journey, or if you're looking for answers to burning questions, you've come to the right place.

Get ready to unlock the secrets of lifelong health and vitality. This is Doctor Talks, real talk from real doctors on the issues that matter to you most.

For having me, I'm super excited to be here and super excited to be joining the team. Yeah, we're so excited to have you. I want to start by introducing you because you are the newest member of Modern med.

You specialize in inflammatory bowel disease. Things like ulcerative colitis and Crohn's disease. But you also work with people on cardiometabolic health, women's health, and general preventative medicine.

Meet the New IBD Specialist

And so I want to just to start with, if you'll tell us, like, how did you start to go down the path of natural graphic medicine and specifically inflammatory bowel disease?

Yeah. Great question. So in general for natural medicine, I always knew that I really liked medicine. I wanted to be in the field of medicine. So when I was going through school undergrad, I was doing things in the pre-med kind of tract.

One of those, things was a job as a medical assistant at a, urgent care clinic in DC. And that was kind of my first experience in the medical system. And at that point, I was very excited about what medicine could be, etc., etc.

and then that experience kind of shifted my mindset a little bit, a little bit kind of disappointed of what that modern medical system looked for a lot of patients in the in the providers themselves, very short visits, in and outs.

Not a lot of follow up communication or explanation of what's kind of going on, with the patient and often left patients feeling very frustrated. Providers burnt out.

So that kind of started my path to wanting to, dive in a little bit more, see what other kind of options were out there. Eventually I did find, natural path medicine, through an integrative clinic here in Maryland.

And that's where the doctor saw what she was doing and was very interested. And then, worked for her for a little bit, ended up, applying to Nash Mathematics School and then started that during their, and then for inflammatory bowel disease specifically.

So after I graduated from Natural Catholic Medical School, I started a residency and I worked with doctor Mark Davis, who is another natural private doctor in the field who does a lot of work with inflammatory bowel disease.

So I spent a lot of time with that.

What Is Inflammatory Bowel Disease?

And so we're very bowel disease population and really fell, in love with treating that population. I think there's so many kind of tools we have in our toolkit to be able to make some significant difference, improvement in people's lives there.

So I've been very drawn to to that side. There. Yeah. Thank you. It's awesome. And I love that you worked with doctor Mark Davis. I think he's incredible.

And we're so excited to have you on the team. And really to be, like, our center for inflammatory bowel disease. And so we're going to go into that today because I wanted to pick your brain, and I wanted to really focus on IBD because we haven't done a video about that yet.

So let's just dive into it. First of all, what is inflammatory bowel disease? Yeah. Great question. So inflammatory bowel disease is an umbrella term for three conditions.

That's all ship colitis Crohn's disease and then indeterminate colitis. Typically all three are characterized by inflammation in the digestive tract. Ulcerative colitis.

We typically see that inflammation in the large intestine. And then for Crohn's disease we can see that inflammation anywhere in the digestive tract from mouth to anus, most commonly in the small intestine, specifically that terminal ileum, and then indeterminate colitis is a diagnosis used for when there's features of both ulcerative colitis and Crohn's disease.

It's not completely clear which is there. Yeah. And not uncommon to see that too, especially in the beginning before, you know, sometimes it'll then morph and we can say, okay, you know, it is Crohn's disease.

We're pretty sure of that. Now. Yeah. And how common is inflammatory bowel disease. Yeah. So we see inflammatory bowel disease mostly in industrialized countries.

North America is actually, where we see the highest prevalence. And here we see about 422 cases per 100,000. What is interesting, though, is that we are seeing that countries, newly industrialized countries, their prevalence is, increasing.

IBD Symptoms and IBS Differences

It was previously thought to be a disease of the Western world. And as we see more countries becoming more industrialized, that those numbers are rising for them to.

Yeah. Do we know why? I think I mean, a lot of it, I think, has to do with some of the environmental factors that are coming into play that we get exposed to with that industrialization that's, yeah.

The changes that come with that. And then what are the main symptoms of inflammatory bowel disease? What's really common in terms of presentation. Yeah.

So, all three typically present with frequent urgent diarrhea can be with or without blood. Oftentimes we'll see a lot of mucus in the stool. There can be abdominal pain often as well.

There can also be extra abdominal symptoms. So things outside of the abdominal tract, things like fever or weight loss, lower appetite, joint pain, there could be rashes, inflammation in the eyes.

And a lot of times people have some hard time differentiating IBS, irritable bowel syndrome from inflammatory bowel disease. More talking about the lay public in terms of they come in and they say, I think I have inflammatory bowel disease, can you just go in and differentiate?

Like, what are the big differences between IBS and IBD? They sound similar, but they're pretty different. Yeah. Yeah. No, definitely. There's a lot of confusion there.

So inflammatory bowel disease is an autoimmune condition. So our immune system is are attacking the body. And we see this true level of high inflammation that can be seen either in endoscopy colonoscopy or through inflammation markers.

Things like people can protect in CRP. That right. We see those being elevated. Yeah. And that's that's that's a big difference where people with IBS will have a normal CRP, a normal rate, a normal cow protection level.

And so we can kind of differentiate that way. And then the blood in the stool is not common with IBS either. No, we don't typically or the extra tests sometimes it's not I mean, sometimes you can have joint pain, but we don't typically expect to see joint swelling or redness, which we can see in that IBD population.

Same with inflammation in the eyes that can. That's more so signs of that inflammatory bowel disease. Yeah. And then we were talking about the risk factors for developing ulcerative colitis or Crohn's disease.

What are some of those things that we think may be associated with a higher risk of developing these things. Yeah. So there's quite a few things. When we think about environment there can be certain environmental triggers.

So things like infection, stress, air pollution, other things like smoking which is actually interesting because it can be protective for also the colitis.

But it actually puts you at a greater risk for Crohn's disease. Not that we typically recommend smoking to prevent ulcerative colitis. But the research is interesting there.

Fascinating. I want to pause you on that one. So I think people like, say that one more time. That's really, really interesting that we see that.

IBD Risk Factors and Triggers

Yeah. So for ulcerative colitis smoking can actually be preventative and protective for disease activity. But for Crohn's disease it is a risk factor.

You're more likely to develop Crohn's disease if you are smoking versus non smoking. In that case though, the risk of smoking outweigh the benefits for ulcerative colitis typically just that's not part of the treatment plan recommended. But it's definitely a consideration too.

If somebody is has ulcer colitis is smoking it and considering stopping. Just something to keep in mind when making decisions there, right. That you may see like an active flare up of symptoms with cessation of smoking.

Yeah. Really interesting. So something like to almost, be more cognizant of if you're going to stop that, you may want to have a doctor's appointment scheduled to talk about potential flare.

Yeah, exactly. Or any preventative things to just to give yourself a little support. Okay. Super interesting. Go ahead. I interrupted you in terms of the risk factors.

Yeah. Yeah. There's other ones too that there's a difference between ulcerative colitis Crohn's. So is one of those things high intake of dietary fiber particularly from fruit and cruciferous vegetables.

Seeing a decrease for the risk of Crohn's disease. But we don't see that in ulcerative colitis. Physical activity can also reduce the risk of Crohn's disease.

And then as well as higher intake of omega three fatty acids compared to the omega six fatty acids. Yeah, specifically. And most of these are just especially except for the smoking.

We'll take that one and put it to the side. But except for those these are all things that we talk about in preventative medicine in terms of like omega three intake, sleep, exercise, healthy diet that kind of thing.

Absolutely. And then there was one meta analysis that looked at 11 studies and included a lot of people with 7208 people diagnosed with IBD, and they saw that antibiotic exposure was associated with an increased risk of Crohn's disease, but not ulcerative colitis.

And then they did a case control study, including 24,000 patients with IBD. And antibiotic. Antibiotic use was associated with a higher risk of developing IBD in general.

Compared to no antibiotic use. So something interesting we really just want to talk about in a biotic overuse there. You're never going to not prescribe an antibiotic when it's indicated and necessary.

But making sure we're not prescribing antibiotics for viral infections, which is actually quite common, not to mention, like all the antibiotics that we use in, in the livestock.

Right. That can be getting into our food supply as well. Okay. Let's go through how do you actually determine somebody's severity of IBD like anybody who's treated IBD before, anybody who's had IBD knows that there's a gradation where sometimes their symptoms are mild and sometimes their symptoms are really severe.

And so how do we get an an idea of where somebody is at on that spectrum. Yeah. Great question. So we typically for we use scoring systems. And so for all sort of colitis that is typically what is most commonly used is something called the Mayo score.

And that's based off stool frequency. Whether somebody is having rectal bleeding. Looks at the and ask Skippy and do we see that inflammation on, on endoscopy active disease activity present there and then physician rating.

And so each of those you can get a score between 0 to 3. And that adds up to a score out of 12. And so somebody with a higher score there has higher disease activity.

And then for Crohn's disease we use something called the Crohn's Disease Activity Index. This has a little bit more input into it.

How IBD Severity Is Measured

It's a score out of 600, things that are considered things like the number of soft or liquid bowel movements in the day, somebody having abdominal pain, how are they generally doing as far as well-being wise?

Is any complications present? Things that we talked about before, like the joint pains, inflammation in the eyes. There's also some complication, things like, you know, fissures or fistulas.

And if those are present, then somebody would get a higher score there. And they also look at weight and compare you to, the general population where you should be and see, what that looks like and that as part of the score as well, you probably should imagine that.

Oh, sorry. When we went back from IBS to IBD, the weight loss piece is another. Yeah, that differentiates that. Can you talk a little bit about that? Yeah.

And so so with inflammation that can contribute both ulcerative colitis and Crohn's disease can can lead to weight loss from the inflammation itself but also from malabsorption.

If you're not able to absorb the nutrients that you're getting from the level of inflammation in your digestive tract. For Crohn's, it's commonly and that small intestine where a large part of our absorption in is happening.

So it greater risk there for for that. Yeah. And with that what lab values may you see altered if there's malabsorption going on. Yeah. I mean, one of the classic ones that we think about for Crohn's disease is B12.

And so we like to check that especially that's generally absorbed at the end of the small intestine, where we

typically classically see Crohn's disease being present.

The other things too, is if there is blood loss and things that we want to check, iron status, that can be allowed to. Yeah. Okay. And then you are on the scoring system.

I don't know if I interrupted you, or we can move on to the next one, too. Yeah, no, just the scoring system can be helpful in general. So we they use it for research purposes so we can have a standard that we compare against to see what the improvement or lack thereof look like with studies.

But it's also helpful on an individual and clinical practice. We can see things that we're doing. Compare what your score is, to where it was previously and, see how you're doing that.

Yeah. Okay. Let's go through the stages of treatment. I really like how you outlined this in terms of like, there's different ways that you say, okay, I'm right here with this patient.

Can you can you go through that in terms of, like, stage one? What does that look like? Stage two. Yeah. So when I'm treating, IBD, I use these stages.

So five stages of treatment. I actually did tailor this from doctor Mark Davis. So he is, the person who created this, this staging system. But it's very helpful.

So stage one is are you safe in an outpatient setting? So are there concerns about the nutrition or hydration status? Are there concerns about those acute complications that we've, mentioned before, things like severe bleeding or bowel obstruction that would require immediate intervention?

We want you to be in a hospital. Next step would be stage two and clinical remission. Clinical remission is are you having symptoms of IBD? Are you having the diarrhea?

Are you having the abdominal pain? All of those symptoms that we talked about above, and this is typically where people come to us, they're having symptoms of IBD and they're trying to either on conventional medications and not getting adequate benefit, or they're looking for other options, or additional options.

There. And then stage three is what we call serologic remission. So we see no, evidence, inflammation in those serologic serologic markers that we're looking at.

So we mentioned them a little bit for the fecal cow protection, which is a stool test and measures inflammation in the digestive tract. DRP and federate, those are two of the main, inflammatory markers we look at.

Do those look normal. Are those within normal range and even optimal range of where we want to see them. And so that's the third stage. And then fourth stage would be histologic remission.

So don't have symptoms of IBD where you're serologic.

IBD Treatment Stages and Monitoring

Values are normal. Do we see the inflammation endoscopy, colonoscopy. Do we see the active disease activity because somebody can be have normal serologic numbers, normal people conversation called protected normal said rate.

Normal. Therapy and still have a low level of disease activity present. And our goal is to get to that histologic remission. If somebody is in histologic remission we call that, deep remission.

And that's a really great prognosis of prevention of some of the things that we talked about down the road that we would like to prevent with IBD. So that's four stage.

And then the last stage, final stage is stage five. And that's maintenance stage. And so from there, once we get you into the historic remission, we like to monitor with the, serial logic markers so that people can protect in CRP said rate, every 3 to 6 months or so to start.

And then, can push that out the more stable somebody is. But oftentimes we'll see a horizon that people can protect in prior to somebody having symptoms.

So it can be a really helpful tool, to kind of keep an eye on the inflammation levels, nip anything in the bud before it becomes in a flare. If possible.

Yeah. Yeah, that's a really interesting one. That is so useful in clinical practice. And sometimes it's hard to get people to actually do it preventatively because they feel good.

It's really tough to get. I mean, that's with everything, right? It's like some people don't want to exercise and lose weight until they, you know, have a heart attack or something.

But, the cow protection piece has been so useful because if you see it creeping out even without symptoms, then how would you like just say you have somebody with ulcerative colitis and they come in and they're like, I feel great.

Like everything's good in their cal. Protectant is like 500. How in how would you start to kind of go about like, what are we going to do with this patient?

Because they they don't have any bloody stool. They're not having diarrhea. What kind of thing do you start to think about there. Yeah. So first up we try to see if anything's changed.

Was there any travel, was there any increased stress going on? Anything that we would think would could cause an increase in this number? And if is that if that is the case, is there anything that we could modulate if there was some new medication or anything else we could potentially think about changing that, etc..

Other options is that there's not any quite clear quote unquote trigger for that higher, vehicle cap protecting. We could think back to some of the interventions that have been helpful earlier for bringing that, inflammation down.

And do we want to cut back on maybe some anti-inflammatory herbs? Or if you are somebody that's doing the FMT, is it time to do, another treatment of that so that we can be a little bit proactive?

The other third thing is sometimes we monitor if somebody feels okay, we'll repeat in a month. And was it just a fluke where I increased a bit and we can monitor and it goes back down without having to do anything?

Yeah okay. And you mentioned FMT. Just tell us briefly we're not going to go in-depth in here, but I want people to know what you were mentioning. We're going to have a separate video where we really dive into FMT, which I'm excited about.

Yeah. So FMT or fecal microbiome transplant is essentially where you take the stool of a healthy donor, and then you take that still and transfer it to another person.

Right now it is approved in the United States for for only treatment resistant crap. However, there's lots and lots of studies and currently ongoing on the use of FMT for inflammatory bowel disease, that are positive.

And so there's a lot of people who will do home FMT and it's something we can talk about. There's a way to do that safely and we can help you through that.

If that's something, someone's interested in. Okay. We we'll look forward to that video. But let's start actually with conventional treatment. So just like current treatments, if you went to see your gastroenterologist, what would that look like in general for inflammatory bowel disease.

Yeah. So if you were going to give typically the medications offered as a by Bayer. So steroids, biologic medications, immunomodulators are the main kind of big guys.

There's typically offered and can be helpful, but obviously some limitations and some people have preferences of what they would like to treat with. Yeah, okay.

And like Remicade that goes into the biologic category prednisone. And we would put into the steroid or glucocorticoid category. So people would probably heard of some of these things.

And then shifting from, from that. And in terms of we will also use those. Right. And we often tell people to stay on the medications.

Diet and Integrative IBD Support

Your GI has given you, but you're needing to get into that clinical, serological and historical remission stages. And so we use other things as well. And so just let's just go through like general categories of some of the things that we'll use in addition to that.

Yeah. And so I mean integrative I feel like we have a lot of tools, to use those things that we can do is that I kind of think about is first targeting inflammation.

And so we can use certain supplements or things like that to target, to reduce inflammation. Also, what we talked about a little bit above is that microbiome, can be something that we modulate to help support that immune function.

And then nutrition is another thing that we look at, that can be, a helpful treatment. Lots of options there too. Yeah. Okay. It makes sense, right. Like, especially if we're talking about antibiotics, potentially being a risk factor, which changes the microbiome, inflammation definitely being part of the etiology that these are the things that we'll target.

This is also what the conventional meds are targeting too. They're anti-inflammatory. They're modulating the immune system. And sometimes they're these extra things are enough to like get somebody over that hump.

Interim version they can be for a longer period of time. And then the other thing you like to do is nutritional changes. So what things can people look into nutritionally that may be actually helping with inflammatory bowel disease.

Yeah. So there's there's a lot of diets on available for those with IBD. So and that have been shown to be effective, I tend to kind of want to hear where a patient is at to choose what is best for them, because some of them can be pretty restrictive.

But there are a lot of effective options. Some of the common options, that people have tend to heard of, have heard of is, the autoimmune, protocol diet or a IPI diet.

And that one is shown to be beneficial in both ulcerative colitis and Crohn's, reducing inflammation markers, reducing disease activity. And the premise of that one is essentially removing, foods that have been known to be inflammatory, in one way or another.

And then, doing a stricter elimination diet and bringing back, some of those food groups one at a time, to see individual if somebody responds, negatively to those food groups, that reintroduction phase can be delayed for some.

So often times it can be a pretty strict diet or a long period of time. So that's something I like to consider and make sure I talk through with patients.

Because it can be challenging. Other diets that are common, talked about for IBD is this, specific, carbohydrate diet

or SCD diet, which is essentially a low carbohydrate diet.

It's grain free, lactose free, sucrose free, again, an elimination diet that can be restrictive. So something we can talk through, and then data to support both U C and Crohn's, a little bit mixed.

But some people find significant benefit on those that diet. The other one too is a specific vegetarian diet. That is a little bit less known but can be really helpful for Crohn's disease.

There's research for Crohn's disease specifically. And that diet focuses on kind of pro, microbiome foods, which is interesting. Again, that overlap between the the microbiome and inflammatory bowel disease.

But foods like brown rice, miso, pickled vegetables, green tea or foundations of that diet, and that's shown to, have improvements for patients with Crohn's disease, and dietary markers and disease activity.

The other one that's common is the low Fodmap diet, that people may be familiar with for IBS. And that can also be helpful for people, with IBD, IBD, for symptom management, research, a little bit mixed as far as the inflammation markers go, decreasing, with that one.

But there can be IBS on top of IBD. So that is another little can of worms that we could go down to with treatment. Yeah, yeah. Super interesting lot of options obviously.

So it's not like we have one treatment protocol that you give everybody that has ulcerative colitis or Crown super personalized to to where they're at.

All right. The other thing I wanted to go over is how is it different from somebody seeing their conventional gastro to somebody seeing you? And is it ever going to be the case that you would suggest they don't see their conventional gastro.

Yeah. Great question. So no, I never recommend not having a gastro. It's very helpful to have a gastro on board, especially when we do need to escalate to those more interventional therapies.

Conventional Care and Colonoscopy

They're great member of the team. And so oftentimes I'd love to work with a gastro if they're open to that. But I mean, as far as differences go between myself and a gastro, typically speaking, one of the main differences is time.

I get to spend a lot more time with patients and dig a little bit deeper. And oftentimes two, I see, my patients at more frequent intervals, especially, when they're not in that acute flare, have more frequent check ins and paying attention to how they're doing and try to catch things a little bit earlier, try to kind of tweak things a little bit.

Other things, as far as testing goes, is often times we do do more in-depth testing and these three as indeed so we talked about this a little bit earlier, but things nutrient testing like vitamin B12, other things like for weight and iron status, looking into all of those things.

The other thing that I tend to test, more frequently than conventional guys is, you know, copper checked in. Oftentimes if somebody, is flaring or having symptoms, I typically test every month and, and pay attention a lot closer, or a lot more frequently, than a conventional gi.

Tends to obviously exceptions to, to that. And then other things too that we think about is, more in-depth is environmental triggers, things that we talked about above.

Is there any nutrition that we can talk about or there's certain lifestyle things like movement, like fiber, like smoking. That we could, maybe modulate, play around with.

Yeah, yeah. Not to say that we're going to recommend smoking, but, to discuss and for sure. And the other thing

guys are so needed for our colonoscopies, especially with IBD.

Can you tell us about why it's so important that it's important for everybody, but it's so much more important by IBD specifically? Yeah, absolutely. And can be such a helpful tool.

As we talked about earlier with those stages of treatment, somebody can have be symptom free from IBD and have no markers of inflammation in the fecal cow protectant and ESR.

Then, I'm CRP, but still have disease activity on colonoscopy or endoscopy. Crohn's disease. And so we want to know that because that inflammation, can put people at risk for those sequelae that we're trying to prevent.

And yeah, so that was super helpful tool. Yeah. To make sure that we are keeping up with. Yeah. And then also just prevention of the increased risk for, for colon cancer, which we see in ulcerative colitis as well.

Do we see it in Crohn's disease as well. It depends where the inflammation is. And so if there is chronic Crohn's disease there can be an increased risk of that kind cancer.

But really colon cancer is something that we can prevent because people we can see polyps and those are going to be pre-cancerous cells. And we can get rid of those before they even turn into cancer.

And so well, you know, some people with ulcers plans are really, you know, worried that, oh, am I going to get colon cancer? I usually tell them you're actually at a good place in terms of, yeah, you have an increased risk that you're going to be monitored much more closely because you're going to get colonoscopy is at a younger age, you know, depending on when they were diagnosed with, you see, of course, but you're going to get them more frequently as well.

So if a polyp does arise, they can cut it out. And then, you know, it won't turn into cancer in that case. So, you know, it's two sides to it, of course.

But that's why it's so important that people get their colonoscopy is 100%. Absolutely. Yeah. I think those are some of the big ones.

IBS, SIBO, and Closing Remarks

The other thing too is, is that what I mentioned earlier is that IBS on IBD within IBD, so often times, somebody might go to a conventional GI with inflammatory bowel disease, use those medications that are very effective for them at decreasing that inflammation.

They're within normal limits. Their colonoscopy endoscopy looks great. But they're still having these IBS like symptoms. And then at that point we can try some other things to dig deeper into that IBS portion.

That can also contribute to inflammation down the line. Even if those medications are keeping those numbers within normal on it. Yeah. You're saying that somebody has inflammatory bowel disease, but they also actually have IBS underlying too.

And so yeah, even when you get inflammation normalized, you still may have those IBS symptoms that are independent of inflammation. Exactly. Yeah. Commonly like bloating gas.

Some people can still have stools even though their colonoscopy looks great. Yeah. Yeah. And that's a that's another good point actually. I've seen Sibo small intestinal bacterial overgrowth.

When somebody with inflammatory bowel disease because anybody can have those things. Right. So you can have both of them. It doesn't mean you can just have one.

Yeah. Yeah definitely. Yeah. Okay. Anything else that we didn't touch on that you think is really important to

mention. We're going to be doing a series of these videos because IBD is complex.

So we're going to hit some more. But anything today that you want to tell people about. Yeah. No I think we did a good cover of IBD. I'm excited for future videos.

There's definitely a lot we can talk about, especially with that microbiome, that we've touched on today, but definitely can dive in deeper. So I'm looking forward to talking a little bit more about that.

Awesome, awesome. And if you're listening and you want to book an appointment with Doctor Nataly, you can do so on the Modern Med website, which will put the link below, and you can schedule a complimentary 15 minute call with her where she'll talk to you about, what she does and if if you would be, or if she would be a good doctor for your case, I should say, and vice versa.

Of course, we want to make sure that we're able to help you with your, your health concerns. And we're also going to be posting this on our Instagram.

So check there for more videos and information about future FMT videos as well. And it was so nice to have you, Nataly. I'm glad that we did this and I'm super excited to continue working with you.

Yeah, thanks so much. It's a pleasure. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health.

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