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Food Intolerance in Irritable Bowel Syndrome: Getting Right Dietary Advice

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Irritable bowel syndrome (IBS) is one of the most common GI/neuro disorders. In a 2025 meta-analysis of 96 studies from 52 countries, the pooled prevalence was estimated at 14.1%, with variations in prevalence rates depending on the diagnostic criteria, subtype, and region [1]. Many patients will have the obvious, and about 85-90% of patients will identify specific foods that trigger symptoms [2]. That's why IBS sufferers limit themselves as far as eating is concerned. There is also a link between food intolerance and IBS symptoms and psychological problems and quality of life [3] – taste is not the only thing.

The difference between food intolerance and food allergy is that food intolerance does not always indicate food allergy. A non-immunological response which is usually dose-dependent. Small quantities are acceptable; higher quantities will lead to bloating, pain, or alteration in bowel movement [2]. The suspects are fermentable carbohydrates (FODMAPs), lactose, fructose, gluten and histamine, as well as, somewhat speculatively, food additives. It is still under investigation how foods cause symptoms. They are probably related to luminal fermentation, distension, activation of mucosal immunity, activation of mast cells, and gut-brain signaling, among other processes [2, 4]. This complexity also sets up a diagnostic maelstrom. When symptoms suggest lactose intolerance, a breath test is acceptable, and it is a common misdiagnosis of IBS [1]. Non-celiac gluten sensitivity is mainly a diagnosis of exclusion, and symptoms might be related not to gluten, but to the FODMAP content [2].

The low-FODMAP diet is the most evidence-based dietary approach to IBS and should be discontinued if a clinical response is not achieved, according to the American Gastroenterological Association. It asserts that the pros and cons of a gluten-free diet are not yet certain [5]. The low FODMAP diet is also second-line in Italian consensus guidelines, which are also complex and involve nutritional risks [2, 6]. Although it has long been discredited, a recent multicenter, sham-controlled study reported that the food-specific IgG test-guided elimination diet could achieve a primary pain endpoint in 59.6% of patients compared to 42.1% of those on a sham diet, and that the most significant differences were seen in the constipation-predominant and mixed IBS groups [7]. This is an important indicator, but there was less adherence in the active arm, the mechanism has not yet been explained, and there was no endorsement of IgG testing from societies at the time of the 2024 review [2]. While it awaits replication, it should reside in trials and not as routine practice.

The job that lies before them is not to pick the correct diet, but to provide any diet in a safe manner. Unsupervised elimination can lead to nutrient deficiencies (e.g., calcium and vitamin D avoidance) and to developing a fear of food and restrictive eating patterns [2]. The AGA and the Italian guidelines emphasize a dietitian-driven individualized approach, structured reintroduction, and a strategy to discontinue what is unhelpful [2, 5]. Future research priorities should focus on developing improved biomarkers to detect intolerances, longer trials examining the relationship of nutritional adequacy and microbiome responses, and research in populations that consume diets different than the Western and Mediterranean diets that have been studied most in the literature. Clinicians need to confirm patients' food-related symptoms rather than

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confirming all the restrictions, and should not get caught up in the commercialization of the testing that has not been proven.

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