Low-FODMAP Diet

A practical guide to understanding FODMAPs, IBS symptoms, restriction and careful reintroduction

The low-FODMAP diet is a structured, temporary dietary approach developed to help some people with irritable bowel syndrome (IBS) identify fermentable carbohydrates that trigger symptoms. It is not designed as a permanent highly restrictive diet. The usual process involves a short restriction phase, planned reintroduction or challenge phase, and then a personalised long-term diet that includes as much variety as comfortably possible.

What does FODMAP mean?

FODMAP stands for fermentable oligosaccharides, disaccharides, monosaccharides and polyols. These are short-chain carbohydrates found naturally in many foods. In sensitive people they may be poorly absorbed in the small intestine, draw water into the bowel and be fermented by gut bacteria, contributing to bloating, pain, wind and altered bowel habits.

The main FODMAP groups

Group	Examples commonly discussed
Fructans	Wheat-based foods, onion, garlic and some vegetables.
GOS	Many beans, pulses and legumes.
Lactose	Milk and some dairy foods in people who do not absorb lactose well.
Excess fructose	Some fruits, honey and products with excess free fructose.
Polyols	Sorbitol, mannitol and related sugar alcohols in some fruits, vegetables and sweetened products.

It is not a list of 'good' and 'bad' foods

Many high-FODMAP foods are nutritious and beneficial for gut bacteria. The purpose is to discover individual tolerance, not to label these foods unhealthy. Portion size also matters: a food may be lower FODMAP at one serving and higher at a larger serving.

IBS should be assessed first

IBS symptoms can overlap with coeliac disease, inflammatory bowel disease, infection and other conditions. A clinician should assess persistent symptoms, especially when there is unexplained weight loss, bleeding, anaemia, fever, a new persistent change in bowel habit or other concerning symptoms.

The Three-Stage Low-FODMAP Process

Stage 1 - short-term restriction

High-FODMAP foods are reduced and suitable lower-FODMAP alternatives used for a limited period, commonly around 2 to 6 weeks. The aim is to see whether symptoms meaningfully improve. Staying in this phase indefinitely is not the goal.

Stage 2 - reintroduction or challenges

Individual FODMAP groups are systematically reintroduced while the rest of the diet is kept relatively stable. A challenge may use increasing portions of a food rich in one FODMAP group over several days, with symptoms recorded. This helps identify which groups and amounts are tolerated.

Stage 3 - personalisation

Foods that are tolerated are returned to the regular diet. Foods that trigger symptoms may be limited according to the person's threshold rather than automatically removed completely. The long-term aim is the least restrictive diet that provides acceptable symptom control.

Why reintroduction matters

Remaining highly restricted can reduce food variety, make social eating difficult, increase nutritional risk and alter the substrates available to gut bacteria. Reintroduction also prevents someone avoiding whole groups when only a particular portion or FODMAP type causes difficulty.

A simple symptom record

What to record	Example
Food and amount	Specific challenge food and portion.
Timing	When eaten and when symptoms began.
Symptoms	Pain, bloating, wind, urgency, diarrhoea or constipation.
Severity	For example 0-10, using the same scale each time.
Other influences	Stress, menstrual cycle, sleep, illness, medications, eating speed.
Outcome	Tolerated, uncertain, or clear reaction requiring later review.

Do not challenge everything at once

A structured sequence makes results easier to interpret. If several foods are changed together, it becomes difficult to know what caused improvement or symptoms. A registered dietitian trained in the low-FODMAP approach can guide the process.

Building Nourishing Lower-FODMAP Meals

Start with foods you already tolerate

The diet does not need to become unfamiliar. Many everyday foods can remain: plain meat, fish, eggs, firm tofu, suitable cheeses, rice, potatoes, oats, quinoa and a range of fruits and vegetables in appropriate portions. Individual tolerances and other dietary needs always take priority.

Protein

Most plain animal proteins contain little or no carbohydrate and therefore no FODMAPs, although marinades, coatings and sauces may contain garlic, onion or other high-FODMAP ingredients. Vegetarian protein choices require more attention to type and portion.

Carbohydrate foods

Rice, potatoes, quinoa, oats and suitable gluten-free breads or pastas can be useful. Low-FODMAP does not mean gluten-free: wheat restriction in this diet is generally about fructans rather than gluten. Anyone being investigated for coeliac disease should not remove gluten before testing without medical advice.

Flavour without unnecessary restriction

Garlic-infused oil can provide garlic flavour because FODMAP carbohydrates do not dissolve into oil in the same way they do into water. Chives, spring-onion green tops, herbs, spices, citrus where tolerated and suitable condiments can also add flavour.

Meal-building framework

Part of meal	Examples to consider
Protein	Eggs, fish, chicken, meat, firm tofu or another tolerated protein.
Carbohydrate	Rice, potato, quinoa, oats or suitable bread/pasta.
Vegetables	Choose tolerated lower-FODMAP types and portions.
Fat/flavour	Olive/rapeseed oil, garlic-infused oil, herbs, spices or tolerated dressing.
Optional extras	Suitable fruit, lactose-free dairy or alternatives, nuts/seeds in tolerated portions.

Adequate energy still matters

People sometimes unintentionally eat much less when starting low-FODMAP because familiar foods disappear. Meals still need enough carbohydrate, protein and fat. If weight is falling, appetite is poor or eating feels increasingly difficult, seek professional support rather than tightening restriction further.

Shopping, Labels, Eating Out & Everyday Practicalities

Ingredient lists

Common ingredients that may need attention during the restriction phase include onion, garlic, inulin/chicory fibre, certain sweeteners ending in '-ol', wheat in larger portions, some milk ingredients containing lactose and concentrated fruit ingredients. Whether an ingredient matters depends on amount, product and individual tolerance.

Low-FODMAP is portion-dependent

A static 'allowed/not allowed' list can be misleading because laboratory-tested serving sizes change as evidence develops. Specialist resources such as the Monash University FODMAP app are useful because they provide tested portions and are updated over time.

Eating out

Restaurants can be challenging because onion and garlic are common foundations for sauces, stocks and marinades. During the short restriction phase, simple dishes may be easier to adapt. During personalisation, known tolerance can make eating out considerably more flexible.

Budget

A low-FODMAP diet does not require an entire cupboard of specialist products. Rice, potatoes, oats, eggs, suitable frozen vegetables, plain proteins and other naturally lower-FODMAP staples can form affordable meals. Specialist labelled products may help but are optional.

Convenience foods

Convenience is important when symptoms, fatigue or executive-function difficulties make cooking hard. Suitable microwave rice, frozen potatoes, pre-cooked proteins, tolerated ready meals and prepared vegetables can reduce workload. Check ingredients rather than assuming all minimally processed foods are necessary.

A practical shopping check

Question	Why ask it?
Is the portion appropriate?	FODMAP content can change with serving size.
Does it contain onion/garlic?	These are common concentrated fructan sources.
Does it contain inulin/chicory fibre?	Often added to bars, yoghurts and 'high-fibre' products.
Are polyol sweeteners present?	Sorbitol, mannitol and related sweeteners can be relevant.
Is this food actually necessary to remove?	Avoid expanding restriction beyond the structured plan.

ARFID, Autism, Eating Disorders & Complex Diets

ARFID and sensory differences

A standard low-FODMAP plan can be particularly risky when someone already has a small number of safe foods. Removing a familiar bread, cereal, yoghurt, fruit or snack may leave too little to eat. In this situation, nutritional adequacy and maintaining safe foods can be more important than following a textbook restriction phase.

Adaptation may mean changing only the most likely high-FODMAP exposures, working with portion sizes, using a gentler version of the diet, or deciding that another symptom-management approach is safer. A specialist dietitian can individualise this.

Autism and predictability

Brand, texture, temperature, appearance and routine can matter as much as ingredients. Substituting several foods at once can create distress and reduce intake. Use predictable changes, visual plans if helpful and one adjustment at a time.

Eating disorders and restrictive eating

The low-FODMAP diet has a legitimate therapeutic use, but its rules can reinforce fear of food or compulsive restriction in vulnerable people. A history of an eating disorder, significant food anxiety or rapidly shrinking food variety should be discussed before starting.

Symptom relief is not a success if the price is inadequate nutrition, escalating food fear or an unmanageable life. The goal is a personalised, expanded diet after challenges - not permanent maximum restriction.

Vegetarian, vegan and multiple-allergy diets

Combining low-FODMAP with vegan, gluten-free, dairy-free or multiple-allergy diets can make protein, calcium, iron, fibre and overall energy more difficult to achieve. Professional guidance becomes increasingly valuable as restrictions accumulate.

Constipation and fibre

Some people reduce fibre unintentionally when they remove wheat, pulses and certain fruits. Others increase fibre too quickly and worsen symptoms. Fibre type, fluid intake, activity and bowel pattern all matter; constipation may need a broader management plan.

When to stop and seek help

Seek advice if symptoms worsen significantly, intake becomes very limited, weight falls unintentionally, food anxiety increases, there are red-flag gastrointestinal symptoms, or the restriction phase produces no meaningful benefit.

Myths, Personal Check-In & Sources

Common myths

“Low-FODMAP is a lifelong exclusion diet.” No - restriction is intended to be temporary before reintroduction and personalisation. **“High-FODMAP foods are unhealthy.”** Many are highly nutritious. **“Low-FODMAP means gluten-free.”** Not necessarily; wheat is often limited because of fructans. **“If a food caused symptoms once, I can never eat it again.”** Symptoms can be dose-dependent and affected by other factors. **“The stricter I am, the better it works.”** Unnecessary restriction can make the diet harder and nutritionally poorer.

Personal check-in

- Have my IBS-like symptoms been medically assessed?
- Am I using low-FODMAP as a short structured process rather than an indefinite diet?
- Do I have enough safe, nourishing foods to complete a restriction phase without under-eating?
- Am I recording portions and symptoms rather than labelling foods permanently 'bad'?
- Have I planned reintroduction challenges?
- Could stress, sleep, menstrual changes, medication or illness be affecting my symptoms too?
- Is constipation, diarrhoea or pain being managed as part of a wider plan?
- Is my diet becoming more restrictive or anxiety-driven?
- Would a registered dietitian trained in low-FODMAP help me personalise this safely?

A message from Space to Breathe Therapy

Digestive symptoms can make eating feel uncertain and exhausting. A low-FODMAP approach can be useful for some people, but it should help you understand your body rather than leave you frightened of food. The destination is greater knowledge and as much variety as your body comfortably allows. Your nutritional needs, sensory needs and emotional wellbeing all matter.

Evidence and further reading

Monash University FODMAP: developers of the low-FODMAP diet; evidence-based information, tested food portions and structured restriction, reintroduction and personalisation guidance.

British Dietetic Association: IBS and dietary guidance, including the role of specialist dietetic support for approaches such as low-FODMAP.

NICE - Irritable bowel syndrome in adults: UK clinical guidance covering assessment, red flags, lifestyle and dietary management.

NHS: patient information on IBS symptoms, assessment and when to seek medical advice.

Educational information only. This guide is not a diagnosis or a personalised low-FODMAP meal plan. Restrictive phases are best undertaken with appropriate dietetic support, particularly where nutrition is already limited.