Innovative GI

Understanding the Low-FODMAP Diet

A Patient Guide to Diagnosing and Managing Your Trigger Foods

What Are FODMAPs?

FODMAP stands for Fermentable Oligosaccharides, Disaccharides, Monosaccharides, and Polyols — a group of short-chain carbohydrates found in many everyday foods (wheat, onion, garlic, certain fruits, beans, dairy, and more). These carbohydrates are poorly absorbed in the small intestine. Instead, they draw extra water into the gut and get fermented by bacteria in the colon, producing gas. In someone without a sensitive gut, this barely registers. In IBS (and often SIBO), the gut is more sensitive to this stretching and gas production, so it's felt as bloating, pain, gas, and altered bowel habits.

The low-FODMAP diet is a structured, temporary process for figuring out which of these carbohydrate groups are actually triggering your symptoms — it is not a permanent restrictive diet, and it isn't designed for weight loss or general "healthy eating."

Who Is This Diet For?

- Most helpful for IBS (all subtypes — IBS-D, IBS-C, IBS-M) with bloating, gas, pain, or altered bowel habits as prominent symptoms.
- Sometimes used alongside SIBO treatment, since the two conditions overlap and can share triggers (see our separate SIBO guide).
- Not typically recommended as a first step for other GI conditions, and not intended as a long-term or permanent way of eating for anyone.

Why We Recommend Doing This With a GI-Experienced Dietitian

This diet has more steps and nuance than a typical food list. Done without guidance, it's easy to get stuck indefinitely in the strict elimination phase — which isn't the goal, and can create new problems of its own. We strongly recommend working through all three phases with a registered dietitian who specifically has experience in GI and low-FODMAP nutrition, rather than following a generic food list alone.

> *Evidence: Studies comparing dietitian-led low-FODMAP education to standard written advice (a generic food list from a doctor's office) found better symptom control and more complete, balanced nutrition with dietitian involvement. Research also shows that patients who try to do this diet on their own — based on their own reading or apps — are more likely to stay in the strict elimination phase far longer than the recommended 2–6 weeks, which raises the risk of nutrient shortfalls (for example, calcium) and unwanted changes to gut bacteria over time. A dietitian also helps interpret the reintroduction phase correctly, since expecting a food to cause symptoms can itself cause symptoms.*

How Well Does It Work?

The low-FODMAP diet is currently the most evidence-backed dietary therapy for IBS. Trials comparing it to a patient's usual diet or to standard dietary advice have found meaningful symptom improvement in roughly half to over 80% of patients, with the clearest benefit for bloating, gas, and abdominal pain, and particularly strong results in IBS-D. A combined analysis of multiple trials rates this as moderate-quality evidence — solid, though not as ironclad as evidence for some prescription medications.

The diet works in three phases. Skipping ahead or stopping after phase 1 misses the point of the process — the real value is in identifying your personal triggers so you can eat as normally as possible everywhere else.

Phase 1: Elimination

Weeks 0–6

Goal: remove common trigger foods to establish a clear symptom baseline.

• All high-FODMAP foods are removed together for 2 to 6 weeks — including foods like wheat, onion, garlic, many fruits, legumes, and lactose-containing dairy.

Evidence: In trials, this phase alone produces a significant drop in symptoms for a large majority of patients — one study found roughly 80% of patients responded during this stage.

• Keep a simple food and symptom journal during this phase.

• This phase is meant to be short and diagnostic, not a long-term diet — it should not continue past about 6 weeks.

Evidence: People who stay in strict elimination longer than recommended face a higher risk of inadequate nutrition and unwanted shifts in gut bacteria. This is one of the most common mistakes made when this diet is attempted without guidance.

Phase 2: Reintroduction

Weeks 6–14 (about 6–8 weeks)

Goal: identify exactly which FODMAP subgroups trigger your symptoms — and which don't.

• Each FODMAP subgroup (fructans, GOS, lactose, excess fructose, and the polyols sorbitol and mannitol) is tested one at a time in a structured challenge, while the rest of the diet stays low-FODMAP.

Evidence: Across studies, the most common trigger groups are fructans (found in wheat, onion, and garlic) and mannitol, followed by GOS, lactose, fructose, and sorbitol — though this varies by person, which is the entire point of testing systematically.

• This step is intentionally structured and is usually best supervised by a dietitian, since timing and interpreting your results accurately both matter.

Evidence: A recent randomized trial found that a carefully structured, blinded reintroduction process gives a more accurate picture of true triggers than testing foods casually — expecting a food to cause symptoms can itself cause symptoms.

Phase 3: Personalization

Ongoing

Goal: build a long-term, less-restrictive way of eating based on what phase 2 revealed.

• Foods and FODMAP groups found to be well tolerated are added back into your regular diet; only your specific triggers, in the amounts that bother you, continue to be limited.

Evidence: This is meant to be the permanent, day-to-day state — most patients end up tolerating the majority of high-FODMAP foods in at least some quantity once personalized.

• Periodically retest foods you're limiting over time, since tolerance can change.

Examples of Higher- and Lower-FODMAP Foods

This is a small sample to illustrate the idea, not a complete list. Two apps are worth having on your phone alongside your dietitian's guidance, not instead of it: the **Monash University FODMAP app**, built by the researchers who created this diet, with a traffic-light food database, certified low-FODMAP products, recipes, and a diary that walks you through the reintroduction phase; and **Fast FODMAP Lookup & Learn**, a free, highly rated app with quick offline food lookup, a symptom diary, a meal planner, and the ability to share your data with your dietitian.

Higher in FODMAPs (limited in Phase 1)	Lower in FODMAPs (generally fine)
• Onion, garlic	• Garlic-infused oil, chives, green onion tops
• Wheat bread, pasta, couscous	• Rice, oats, quinoa, gluten-free bread
• Apples, pears, mango, watermelon	• Grapes, strawberries, blueberries, oranges
• Milk, soft cheese, yogurt (lactose)	• Lactose-free milk, hard cheese, almond milk
• Beans, lentils, chickpeas	• Firm tofu, eggs, meat, fish
• Cashews, pistachios	• Almonds and peanuts (small servings)
• Mushrooms, cauliflower, artichokes	• Carrots, spinach, zucchini, bell peppers
• Honey, high-fructose corn syrup	• Maple syrup, table sugar (in moderation)

Practical Tips for Success

- **Watch for "FODMAP stacking."** Most low-FODMAP foods aren't FODMAP-free — they just contain a small enough amount to be tolerated on their own. Eating several low-FODMAP foods together in one meal, or in quick succession, can add up past your personal threshold and trigger symptoms even though each food seemed "safe." If this seems to be happening, try leaving 2–3 hours between meals and snacks and avoid combining many different low-FODMAP foods in one sitting.
- **Check labels for hidden FODMAPs.** Garlic powder, onion powder, and chicory root or inulin are often tucked into ingredient lists under terms like "natural flavors," "spices," or "dehydrated vegetables." Inulin/chicory root in particular shows up often in gluten-free breads, protein powders, and products marketed as high-fiber or "prebiotic" — exactly the products people often reach for on this diet.
- **Low-FODMAP is not the same as gluten-free.** Wheat is high in FODMAPs because of the fructans it contains, not the gluten. A "gluten-free" label doesn't guarantee a product is low-FODMAP — and, as above, gluten-free products often have inulin or chicory root added back in.

Long-Term Considerations

- **Don't stay in Phase 1 indefinitely.** The strict elimination phase is diagnostic, not a destination — prolonged, unsupervised restriction has been linked to nutrient shortfalls (such as calcium) and unfavorable shifts in gut bacteria, including a reduction in beneficial species like *Bifidobacterium*.
- **This diet isn't a good fit for everyone.** If you have a current or past history of an eating disorder or disordered eating, please tell us before starting — this diet's restrictive structure can be risky in that setting, and any attempt should involve a dietitian with relevant experience.
- **Reintroduction is the whole point.** Skipping it turns a short-term diagnostic tool into an unnecessarily restrictive long-term diet.

When to Contact Our Office

- You're having trouble progressing through the phases, or aren't sure how to interpret your reintroduction results
- Unintended weight loss, new or worsening abdominal pain, or blood in your stool
- You notice the diet becoming a source of significant anxiety or restrictive eating patterns
- Before starting this diet if you have a history of an eating disorder, are pregnant, or have diabetes or another condition requiring careful dietary management

This guide supports the personalized plan discussed with your provider and is not a substitute for individualized medical or nutritional advice. Please work with your provider and a registered dietitian before starting, modifying, or stopping this diet.