Volume 11, Issue 8
August, 2025

When Should I Begin Adding Foods to My Diet?

by Wayne Persky

Occasionally, a new member of our discussion and support forum will adopt an elimination diet, and after a few weeks, they ask, "How will I know when I'm in remission?" And then they ask, "When should I begin adding foods to my diet? And what food should I try to add first?"

Those are relatively difficult questions that don't have a "neat" answer. For example, many of us have our own unique definition of remission. My own definition is "When our bowel habits return to the same pattern we experienced before we developed microscopic colitis (MC), we're in remission." But even that is not a "neat" answer, because our bowel movements, and their consistency, depend upon our diet, and for those of us who are controlling our symptoms by making diet changes to eliminate the foods that cause us to react, obviously our diet will be drastically changed, which will probably significantly change the consistency, and possibly even the frequency of our bowel movements.

It's not surprising that most of us are anxious to add foods to our diet.

There are many reasons why we feel the need to expand our diet. Up until now, we've enjoyed a wide variety of foods. Suddenly placing so many of those foods off limits seems almost overwhelming. And what about our nutritional needs? We have our doubts that such a restricted diet can maintain our health (as if we have any health left to maintain at this point).

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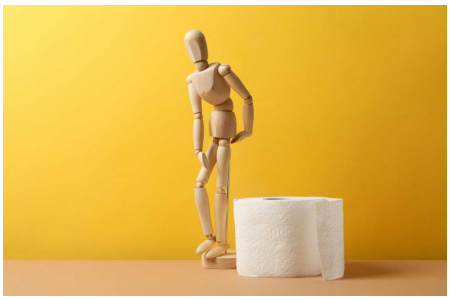
We want to get out and enjoy life a little, again. If we're able to expand our diet, maybe we can begin to attend some of the social functions that we've felt the need to decline ever since our symptoms became so severe. And we miss many of the foods that we once found to be so enjoyable. Probably the most important feature of being able to add that first food to our diet is the hope that simple event endows upon us. It gives us reason to believe that one food will lead to multiple foods, and eventually we'll get our life back.

Conversely, there are precious few reasons why we wouldn't want to expand our diet. But unfortunately the foremost reason why we wouldn't want to expand our diet is so formidable that it's the equivalent of the elephant in the room. Namely, if we try to add foods to our diet too soon, or if we make a poor food choice, the resulting flare might put us back at square one, if we are unable to stop it promptly.

We want to get out and enjoy life.

But don't be too eager to add foods.

That said, normally, a failed attempt to add a food will result in a short-lived flare. If we immediately revert to our safe diet again, the flare should end in a day or so. In most cases, relapses only occur when we continue to make mistakes with our diet. Even so, the risk justifies some careful consideration to be relatively sure that we are ready before deciding to try to begin adding foods to our diet.



The intestines heal slowly.

As we learned in the October, 2024 Microscopic Colitis Foundation Newsletter, the inflammation associated with Inflammatory Bowel Diseases (IBDs) damages intestinal stem cells, and this is the primary reason why the intestines heal so slowly. If you want to review the information in the newsletter, here's a link that will allow you to either read or download a copy of that newsletter:

https://www.microscopiccolitisfoundation.org/uploads/5/8/3/2/58327395/1924a864178.pdf

Trying to predict when anyone can add new foods is a guessing game, at best.

Fortunately, we can reach remission long before our intestines actually heal. But the inflammation needs to be under control, and healing should have at least begun, before we will have much success trying to successfully add new foods to our diet. The rate at which healing of our intestines will progress is surely dependent on a number of issues, and this list may not be complete.

1. The extent of intestinal stem cell damage due to the fact that we have an IBD
2. The degree to which we have our inflammation under control
3. Nutritional deficiencies — extra protein, vitamin D, and magnesium, and in some cases, zinc
4. The length of time we have reacted before we began our treatment
5. The amount of damage that our intestines have actually accrued during that time
6. The healing capacity (robustness) of our immune system
7. Our age (the older we get, the weaker our immune responses become, so the slower we heal)

8. Chronic stress, and the resulting stress hormones like cortisol
9. Sleep deprivation
10. Infections (which divert the immune systems focus)
11. Medications such as immunosuppressant drugs, chemotherapy, or radiation treatments
12. The fact that we have an autoimmune disease that causes fatigue and limits our energy
13. Poor lifestyle choices such as smoking, or excessive alcohol consumption, for example

If we've just finished a budesonide treatment, or we're still taking budesonide, we need to wait until the treatment ends, and then wait at least a few more weeks before attempting to test any new foods, because budesonide will very likely mask any food reactions, and the effects of budesonide will last a few weeks after the treatment is ended.

How do we decide which food to try to add to our diet first?

Choosing that food may be easy for some of us and difficult for others. But here are some guidelines to simplify making that choice.

Whether we use an elimination diet, or order EnteroLab testing,

please be aware of certain rules regarding food selection that we have learned in the school of hard knocks, and by sharing experiences with thousands of actual MC patients. Probably the most important rule is that We tend to react to the common foods that we have eaten all our life. Consider the EnteroLab tests. They test all of the foods that are known to cause reactions for MC patients. Occasionally, there are some rare, or very uncommon food sensitivities in some cases, but virtually all of us react to one or more (usually more), or all of the 15 foods for which EnteroLab offers tests.

When searching for foods to add to our diet, note that if only 15 foods are commonly known to cause food sensitivities, that leaves many, many, other foods that should be safe for us, and the safest options will be among those that we haven't been eating every day in the past (although that doesn't mean that any of the foods we've often eaten in the past can't be safely added back into our diet (other than gluten). At the very least, though, we need to test each new food under consideration, to make sure that it's safe.

For those who used an elimination diet to reach remission, here are a few guidelines:

Gluten, casein, soy, and chicken eggs are known as the big four. And those four foods are almost always permanent sensitivities. So if we have decided to experiment with adding foods into our diet, we probably wouldn't want to begin by selecting one of those foods to try to add to our diet, unless we have nerves of steel.

Foods in the "11 other antigenic foods" category may not be a great initial choice, either. Of the "11 other antigenic foods" for which EnteroLab offers a test, some (or all) of them may cause permanent sensitivity problems, or they may not. Specifically, those foods are chicken, beef, pork, tuna, oats, corn, rice,

almonds, cashews, walnuts, and white potato.

Therefore, while we might be able to add some (or even all) of these foods back into our diet, they're known to cause problems for some MC patients, so we'll need to be especially careful if we choose to test them, and remember that they should be treated with suspicion, because they might turn out to be a problem after we've eaten them for a while (weeks or even months).

The longer we allow our digestive system to heal, the more likely we will be able to tolerate new foods, and the greater the selection of foods that we may be able to tolerate (although there are no guarantees, because we don't all heal at the same rate, and some of us are more sensitive than others).

Eventually we'll want to consider the “big four”.

As we continue to heal, we will get to the point where we want to consider adding foods from the "big four" category. There's little point in attempting to add gluten back into our diet, because virtually all of us are sensitive to gluten, either by conventional sensitivity, or by non-celiac gluten sensitivity. Remember, there's no approved medical test that can detect non-celiac gluten sensitivity, so it's best to always consider gluten off limits. But since there's a possibility that we might be able to enjoy either soy, chicken eggs, or dairy products, again. we'll probably eventually want to test them (one at a time), after we've been in stable remission long enough to have accrued some intestinal healing.

If we do choose to order EnteroLab testing,

then the discussion that comes with our test results should allow us to choose which foods we may be able to safely add into our diet with much more confidence, because if our immune system is not producing antibodies to any of those foods, then they should be safe for us, and that includes the "11 other antigenic foods".

But note that the overall score on that test (the 11 other antigenic foods) definitely matters, because the higher the score, the greater the chances that those foods will always be a problem. An overall score below 10 on that test should mean that none of them are a significant problem, nor are they likely to become a problem, unless your situation changes drastically in the future. A low score such as 10 to 15 suggests that the risk of most of those foods causing a problem should slowly fade over time. A high score, such as 30 or 40 implies that they may always be a problem, even the foods with the lower ratings (the 1+ foods).

> **We tend to react to common foods.**

> **Avoid adding gluten.**

How to test new foods.

When testing new foods, never test more than one food at a time, because if we test more than one food at the same time, and we have a reaction, we won't know which food caused the reaction. We should start by eating a small serving of the chosen food the first day, and on the second day, we should eat slightly more of the same food. On the third day, we can eat a normal serving of the food.

If we don't experience a reaction by the end of the third day, that food is probably safe to add to our diet. Obviously though, if we have a reaction at any time during the trial, we should stop the trial and consider that food to be off limits, at least at our current stage of healing. It might or might not be a candidate for retesting after much more healing, but there's no point in retrying it anytime soon. If we have a reaction while testing a food, we need to wait a week or two after the reaction ends, and our digestive system recovers and stabilizes again, before trying another test food.

The bottom line is:

We need to listen to our body. Our body will usually offer clues that will help us to decide whether or not we are ready to add new foods to our diet. If we seem to be in solid remission, and we feel confident that we should be able to begin adding foods to our diet, then we probably are indeed ready to try adding new foods to our diet. On the other hand, if we don't feel confident about testing new foods, either because our symptoms haven't fully resolved, or we're just not sure that we're ready, we're probably not ready.

Looking Deeper into the Details of Fine-Tuning Our MC Recovery Diet

by Wayne Persky

As we all know, developing a recovery diet that is safe, and suitable for our own particular situation, is rarely simple. Many of the foods we have to eliminate have been part of our diet for most of our life, and not only are some of the foods in our diet habit-forming, but some are actually addictive. (foods that contain casein and gluten, for example). And even if we order Enterolab testing so that we can track down all of the common foods that may cause our immune system to produce antibodies that trigger a reaction, that still usually leaves many questions about various food issues that may cause digestive problems during our recovery, even though they may not cause our immune system to produce antibodies.

Good health requires protein and fat.

These are the only essential nutritional requirements that we need to be concerned about during recovery. Protein is essential for building cells, and rebuilding (healing) damaged cells, and although we have to avoid large amounts of fat because we can only absorb limited amounts of fat when we are reacting, a limited amount of fat is necessary in order to prevent what's known as protein poisoning, or "rabbit starvation".

Carbohydrates and fiber are optional.

Although many people mistakenly believe that a certain percentage of carbohydrates in their diet is essential for good health, along with fiber, this is simply not true. Although a certain percentage of carbohydrates and fiber in the diet may be normally tolerated, they are by no means required for good health. Carbohydrates are a good source of quick energy, but unless we're athletes, so that we burn carbs for energy, carbohydrates are proving to be the driving force behind the obesity problem of the world's population.

Consider that carbohydrates (primarily in the form of grain) are what feedlot operators feed to livestock, when livestock are being fattened for slaughter. Because most feedlot animals are ruminants, fiber must be added to their rations in order to keep their digestive systems working smoothly, but note that carnivores (at least, in the wild) typically eat no significant amount of fiber, so it's obviously not essential for good health (for carnivores).

Why did our nutritional requirements evolve this way?

Despite a widespread belief that humans evolved eating a variety of foods, hominins first appeared on this planet about 6 million years ago, in the Miocene epoch, and our ancestors evolved during the Pliocene, the Pleistocene, and finally into the Holocene (Smithsonian Institution, 2024, January 3)[1]. Early on, wildlife

the Pleistocene, and finally into the Holocene (Smithsonian Institution, 2024, January 5)[1]. Early on, wildlife populations were large, and looking at archaeological evidence from the Pleistocene period, for at least 2 million years, our human ancestors evolved as carnivores (Dunham, 2021, April 7)[2]. In fact, the evidence indicates that we evolved as apex predators. Consequently, our digestive system evolved accordingly.

Our strong stomach acidity proves that we evolved as apex predators.

Archaeological evidence indicates that our ancestors primarily hunted large and medium-sized animals, the meat of which had a high fat content. But basing their diet on the meat of large animals such as mastodons and mammoths, means that the meat from individual animals was probably consumed for days, and even weeks. And because refrigeration was not available back then, bacterial content of the meat almost certainly increased rapidly, especially in warmer climates.

Surely this is why, even today, the acidity level of our stomach is exceptionally high when compared with omnivores, and even other carnivores (because most predators don't hunt megafauna — they hunt medium-sized game, such as deer and antelope, which can be devoured in just one or a few meals, so that bacteria levels usually remain relatively low, by comparison).

Additional evidence can be found in our fat cells.

Omnivores store fat in a relatively small number of large fat cells. Predators (including humans) store fat in a much larger number of smaller fat cells. Our ancestors were such efficient hunters that the archaeological evidence suggests that they played a primary role in the extinction of certain large animals, such as mammoths, mastodons, and giant sloths.

> **Protein and fat are the most essential.**

> **Minimize fiber.**

Hunters became hunter- gatherers as wild game populations decreased.

As human populations increased, and they began to put pressure on wild game populations in many parts of the world, periods of inadequate meat supplies began to occur with increasing frequency, and humans began to eat fruit, nuts, and various other plant-based foods, in order to supplement their diets.

The Neolithic period converted hunter- gatherers into farmers.

Living as nomadic Hunter gatherer tribes probably worked for a few hundred thousand years or so, but by the time the Neolithic period began, the development of agricultural techniques appeared to be their salvation. By then, nomadic tribes of humans were placing more demands on the planet than it could provide, and most tribes began to settle down in permanent or semipermanent camps, to pursue an agricultural lifestyle, in hopes of warding off starvation.

A lucky break inspired agricultural development.

At some point between 10,000 and 40,000 years ago, two separate (wild) species of grass, einkorn wheat (Triticum monococum), and goat grass (Aegilops speltoides), crossed, and by a stroke of good fortune, their offspring were fertile. Although einkorn wheat is a diploid, and has only 14 chromosomes, the cross produced what's now known as emmer wheat. If the cross had resulted in a diploid (two sets of chromosomes) arrangement, the offspring would have been sterile. But emmer wheat has a tetraploid arrangement, and the offspring were fertile.

Archaeological evidence suggests that both einkorn wheat and emmer wheat were domesticated and produced agriculturally by at least approximately 8000 or 9000 BC in Turkey and Syria (Encyclopedia of life, n.d.; Encyclopedia of life, n.d.).[3, 4]

About 7000 BC, a second lucky crossbreeding occurred.

This cross involved wild emmer (Triticum. Turgidum, subspecies dicoccoides) and a different species of goat grass (Aegilops tauschii). The cross produced Triticum aestivum, a hexaploid with 42 chromosomes — a very complex arrangement of six sets of 42 chromosomes each (Crop Origins, n.d.)[5]. This hybrid provided the basis for modern wheat.

This event also created the phenomenon of gluten sensitivity.

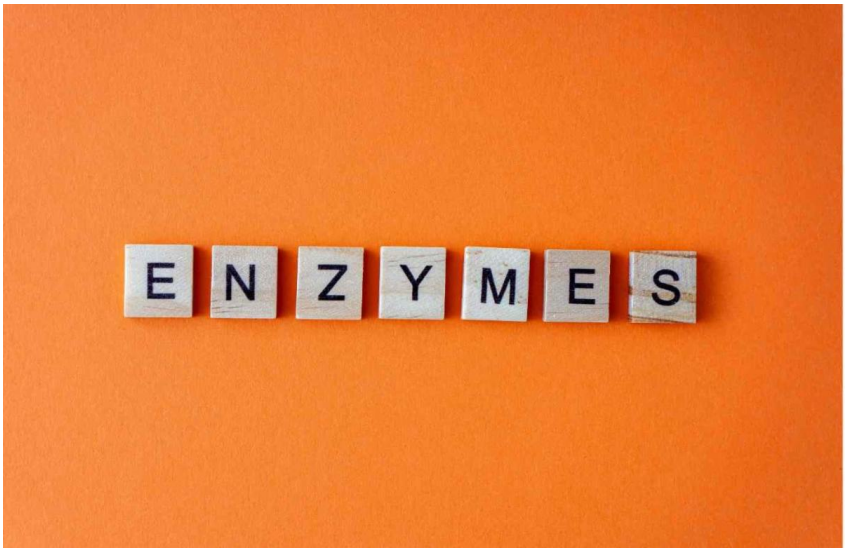
Unfortunately, the human digestive system had never been exposed to molecules of this complexity during its evolution, and it had no way to produce the enzymes necessary to cleave many of the amino acid chains that resulted from the attempted digestion of this complex wheat species, or the resulting domesticated cultivars that were developed from the species. This opened the door to the development of gluten sensitivity, and celiac disease.

And untreated gluten sensitivity leads to other food sensitivities,

by causing increased intestinal porosity (leaky gut), which then perpetuates the inflammation associated with food sensitivities. And chronic inflammation tends to lead to other digestive issues, such as microscopic colitis (MC). Although medical researchers have apparently never studied this issue, (so this is strictly my opinion, and not medically proven fact), the shared experiences of thousands of members of the MC Discussion and Support Forum suggest that once the immune system begins producing antigliadin antibodies, those antibodies tend to dominate our immune system as long as they remain elevated. Once the antigliadin antibodies decline below a certain threshold level (which probably varies by the individual), then our immune system begins to produce and detect antibodies associated with other foods (proteins) in our diet. It appears that it usually takes approximately 3 to 6 weeks of following a gluten-free diet before

our immune system is able to detect other food sensitivities, reliably.

Food sensitivities are always associated with proteins,
with one exception — mammalian meat allergy, which is caused by an infection spread by ticks, also known as alpha gal syndrome. The reaction is directed against a carbohydrate (Galactose-α-1,3-galactose) found in the cells of most mammals other than higher primates.



Intestinal inflammation supresses enzyme production.
Research shows that even low-grade inflammation interferes with the production of enzymes, digestive efficiency, nutrient absorption, and barrier function (Peuhkuri, Vapaatalo, and Korpela, 2010). And research from as far back as 1997 concludes that, . . . "Subclinical small intestinal disease is common in the two main forms of microscopic colitis." (Moayyedi, et al.,1997) This is why the inflammation that is associated with MC causes us to lose much to most of our ability to produce the enzymes we need to properly digest foods, beginning with lactase, and progressing through the other enzymes that are produced in the small intestine. When the inflammation is suppressed, and healing begins, enzyme production resumes in the reverse order by which it was suppressed. In other words, lactase is the last enzyme for which production resumes as our intestines heal. Enzyme production isn't always restored to full normal levels, but the more our intestines heal, the more likely we are to regain normal or near normal enzyme production.

Limited enzyme production is the reason
why smaller, more frequent meals work best for us while we are recovering. And this is also the main reason why simpler diets, that include only a very few easy-to-digest foods, typically allow us to reach remission sooner than more complex diets which may include one or more items that might prevent us from ever reaching remission

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Fiber must be minimized.
Fiber doesn't cause our immune system to produce antibodies, but it irritates our already highly inflamed gut. Research published back in 2006 shows that the way that fiber promotes "regularity" is by tearing (physically damaging) epithelial cells in the colon, causing them to release mucus, as a natural defense mechanism, which then has a laxative effect to promote bowel movement (Miyake, Tanaka, and McNeil, 2006). But the problem with this procedure is that the physically damaged cells must then be replaced by new cells, and cell healing is a function of the immune system, which is already overworked whenever MC is active.

This process may work fine, when digestion is normal, and healing is being handled normally. But when

MC is active, the need for physical repair in the gut, just due to the inflammation, and the physical damage caused by active MC, continues to accumulate, because the chronic inflammation prevents healing from taking place. Obviously, under these conditions, the gut certainly doesn't need the additional irritation caused by fiber. Therefore, all vegetables should be peeled and overcooked, in order to minimize fiber, and facilitate digestion.

Sugar should be minimized.

Because of the reduction in enzyme production, any sugar in more than very small quantities, will tend to pass into the colon partially digested, where it will be fermented by opportunistic gut bacteria, producing gas, bloating, cramps, and diarrhea. Sugar alcohols, especially (which are often found in fruits), should be avoided, because they cannot be digested even when our digestive system is functioning normally. The primary sugar in many fruits is fructose, and fructose must be digested by the liver, rather than the digestive system. Research shows that Crohn's disease and ulcerative colitis cause an elevated risk of liver disease, suggesting that MC might carry a similar risk. For that reason, and the fact that most fruits contain significant amounts of fiber, and sugar alcohols, minimizing fruit while we are recovering is prudent. Recently published research shows that for IBD patients, a high sugar diet inhibits healing, and worsens IBD symptoms (Pelc, 2023, June 20).

Certain carbs are easier to digest than others.

After the fiber content of carbs is minimized, the ease of digestibility is determined primarily by the type of starch content. Carbohydrates typically contain two types of starches. Most common starches are roughly 70% amylopectin (by weight), and 30% amylose, but this percentage depends on the source, of course. Waxy potatoes, waxy corn, and glutinous (medium grain) rice, contain higher percentages of amylopectin. Glutinous rice, waxy potato starch, and waxy corn, for example, can contain up to 100% amylopectin,

which makes them very easy to digest. Yellow and red potatoes are considered to be waxy potatoes, while russets are considered to be starchy potatoes.

At the other extreme,

long grain rice, amylomaize (corn is known as maize, in many parts of the world), and russet potatoes, are not as easy to digest. Amylomaize, for example, typically has about a 50% amylose content. As a general rule, glutinous rice, and yellow and red potatoes, are easier to digest than long grain rice, and russet potatoes. For baking potatoes, however, russets usually work better, because they are able to hold together better when baked.

Sweet potatoes may be an alternative choice

for those of us who are avoiding white potatoes. Sweet potatoes are usually promoted as being better for our health than ordinary potatoes, but that's because they contain insoluble fiber, which is claimed to speed up digestion (although that's simply because insoluble fiber can't be digested), and promote regularity. We've already discussed how fiber promotes regularity, and that probably explains why some of us have trouble tolerating sweet potatoes — it depends on our fiber tolerance. If you find that sweet

potatoes don't work well for you, it's probably due to the fiber content, or the combination of the additional fiber and sugar. Based on 100 g samples, compared with the 1.4 g of fiber in a white potato, sweet potatoes contain about 2.4 g of fiber. And compared with the 1.6 g of sugar in a white potato, sweet potatoes contain about 5.5 g sugar.

However, those of us who have diabetes should note that
although they may be easier to digest, high amylopectin starches are associated with a high glycemic index. I realize that anyone who has diabetes is surely aware of this, but I would be remiss if I didn't mention that issue here. The glycemic index of potatoes can be lowered by cutting them into cubes, blanching them in hot water for half an hour, and cooling them slightly before cooking them. Doing this also helps to make them more digestible

Cereal (grain-based) starches are typically considered to be more digestible than root (potato) starches, and therefore, they usually have a higher glycemic index. Long grain rice has a lower glycemic index than glutinous rice. The more easily a starch can be digested, the higher the glycemic index is likely to be.

When using starches for thickening sauces, root starches typically thicken at lower temperatures (which makes them handy for thickening a sauce soon after removing it from the stove), while grain based starches (such as corn starch) thicken at higher temperatures (making them useful for thickening sauces, soups, or broths relatively early in the cooking process).

Our food is our medicine.

Remember, when we're treating our disease by using our diet, our food is our medicine, and just as we wouldn't use any medicine that makes us sicker, without providing any benefits, we can't afford to allow any food into our diet that might prevent us from reaching remission, while we're in the recovery stage, nor can we afford to allow any food in our diet that might lead to a relapse, after we're in stable remission.

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He posts a new blog about once a week. Here are the titles of the most recent. Click the button at the top of the newsletter to access.

A GOOD NIGHT'S SLEEP PROBABLY DOESN'T HAPPEN THE WAY MOST OF US PICTURE IT (PARTS 1 AND 2)

ALCOHOL MAY HELP US FALL ASLEEP, BUT INTERFERS WITH SLEEP QUALITY

DISTINGUISHING BETWEEN HISTAMINE INTOLERANCE AND MCAS

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