

100 Supplements for IBD

The supplements, herbs, probiotics and nutrients that matter in Crohn's disease, ulcerative colitis, indeterminate colitis and microscopic colitis. The evidence behind each one. The exact products worth buying.

The most comprehensive guide of its kind ever created

By **Andrew Kornfeld**, founder of **Systema Health**

Version 7.2 · September 2026

Every product links to my Fullscript dispensary · ships within the US

FOR

the Systema Health IBD community, my clients and members whose love, courage, and way of meeting adversity inspire me every day, and among them, the people I have watched arrive at remission and stay there.

For the millions of individuals living with IBD around the world: this is a disease we can tackle together.

You can find the community at ***systema.health****.*

Before you read

Please read this first.



Please read this. I am a health educator and a health coach, and I am not your doctor. I practice a modality of my own development called **systems-based health coaching**, which examines every part of an IBD patient's life to help them achieve long-lasting remission. With the people I work with directly I make strategic suggestions and at times give health advice. This guide is not that: it is a tool you use with your own medical team. **Nothing in this guide constitutes medical advice, diagnosis, or treatment.** In my work I have spoken with hundreds of gastroenterologists and thousands of people living with IBD, and I believe strongly in following the science and in getting explicit approval from your medical team before making any change. Never stop, start or change a medication because of anything you read here; bring it to your gastroenterologist, your GP, or your integrative practitioner instead. Doses appear as they were used in published studies, never as a dose for you. I earn a small commission when you buy through the links in this guide; every product link opens my Fullscript dispensary, which ships within the US only. That is how a free guide stays free. If you live outside the US and want help getting hold of a supplement, write to help@supplementsforibd.com and we will do what we can.

1 **Before anything, first make sure you have a medical team you trust.** A gastroenterologist who knows your disease, plus your GP, and additionally an integrative practitioner if you feel that is necessary. Untreated inflammation is silently destructive, and only they can see it, with scopes, imaging and labs. Nothing in this guide replaces them; bring it to your next appointment instead.

2 **Second, a diet and lifestyle strategy.** Food is the ground everything else stands on. There is no single IBD diet, but several have been adapted to work well here (the Specific Carbohydrate Diet, IBD-AID, a modified Paleo AIP, the Mediterranean diet); pick a reputable one, make modifications to it with your team and your own tolerance in mind, and give it a real chance. Then the rest of the lifestyle: exercise you actually enjoy, sleep you protect, a meditation or breathing practice, time outdoors, and a supportive community, the people who hold you up. Supplements rarely do their best work on top of a diet that is feeding the fire, or a body that never rests. If you want help building this, it is what I do. You can work directly with me: **systema.health/apply-now**.

3 **Third, supplements and herbs.** That is what the rest of this guide is for, and it belongs in third place on purpose. Yet with the first two in place, I have watched a well-built supplement and herb strategy become the deciding force between flaring and remission, and that is why this guide exists. Start with the five on the next page, one at a time, then come back for the why.



1 Medical team **2** Diet & lifestyle strategy **3** Supplements & herbs

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Bring it to your gastroenterologist, your GP, and/or your integrative practitioner.

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Start here

Five things you can do today

Most people with IBD who pick this up want to *do* something right now. Here are the five supplements I believe in most, each with the exact product and a link. Take these actions, then come back for the why, the evidence, and the other ninety-five.

> **The order matters:** medical team first, then a diet and lifestyle strategy, then supplements and herbs. "Please read this first" says why. Get the foundation in place, then add these five, one at a time.

To order today: click a button below. It opens the product in my Fullscript dispensary; create a free account at checkout (name, email, US shipping address) and Fullscript ships direct. All five together: go.supplementsforibd.com/the-five. Details in "How to buy" in Section K. Questions or outside the US: help@supplementsforibd.com.

1 Curcumin



Thorne, Curcumin Phytosome (Meriva) NSF · 120 caps

The most-studied anti-inflammatory plant compound in IBD, with trials in both UC and Crohn's. If you can only afford one thing here, this is it.

Buy on Fullscript

2 Quercetin



PERQUE, Repair Guard · 90 tabs

Calms mast cells and histamine reactions. Thin human IBD data, strong biology, and the one I've watched help the most people over a decade.

Buy on Fullscript

3 Omega-3 EPA/DHA



Nordic Naturals, ProOmega 2000 Lemon · 60 softgels

Fish oil in the triglyceride form. Mixed trial record, but the UC trial that measured calprotectin was positive.

Buy on Fullscript

4 Bovine immunoglobulins (SBI)



Microbiome Labs, MegaIgG2000 · caps or powder

Antibodies that bind bacterial toxins in the gut before they reach the wall. Dairy-free. Strong case series in refractory IBD.

Buy on Fullscript

5 Vitamin D3



Jarrow Formulas, Vitamin D3 5,000 IU · 100 softgels

Low in most people with IBD; pooled Crohn's trials show fewer relapses. A cheap blood test tells you the right amount. Standalone D3.

Buy on Fullscript

How to start them

One at a time, ten to fourteen days apart, on a diet and a medical plan your team already knows about, so you can tell what each one is doing.

Track four things on paper: stools, energy, pain, sleep. Test vitamin D before you start and again after three months; the right amount is a lab value, not a guess.

The full three-page entry for each of these begins in Section A, with the trials, the doses as studied, and my notes.

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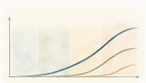
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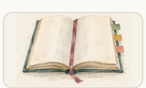
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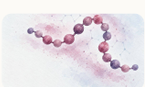
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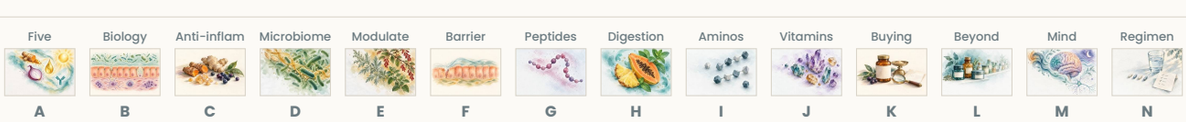


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Entries carry a stable ID (like **C-08**) that never changes between editions, and a display number (1–100) that may. Talk about entries by ID. Every product links to my Fullscript dispensary (US shipping only); the newest version of this guide is always free at **supplementsforibd.com**.



Never make changes to your protocol without consulting your gastroenterologist.

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★ = highlighted with a full product card. On a screen, every line is a link; the page number is where the entry's card, or its row in the section list, begins.



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A word to the people this guide is for

If you're a patient, read this.

Dear patients, friends, and family,

I believe in you, and I believe that healing and remission are possible for you. I have watched it happen too many times to say otherwise, and I live it myself.

Something is changing in the world. For most of the last century IBD was considered a disease of early-industrialized countries. It is now rising almost everywhere it has been measured. A 2025 study in *Nature* that pooled data from around the world describes the pattern in stages: new diagnoses accelerate in a region, and then the number of people living with the disease compounds for decades. Global estimates put that number in the millions worldwide; the graph below shows the shape of the rise. Researchers are studying why, and the candidates are environmental: diet, antibiotics, urban living, and pollutants among them. None is proven. I read that as a reason for hope. What rises with the way we live can, at least in part, be answered by how we live.

That is the conviction behind this guide: an individualized diet, a lifestyle that protects sleep, movement, and connection, and a small number of well-chosen supplements can be part of a plan of care that changes the course of a life. It is not a promise. Some people do everything right and still have active disease; that is the disease, not a failure.

Your medication, and how long you take it, is a conversation for you and your gastroenterologist, and nothing here replaces it. In my experience, oftentimes taking supplements alongside medications increases their efficacy and also may reduce potential side effects.

You are not alone in this. If you want a hand, I work with people one-on-one: **systema.health/apply-now**.

If you're a gastroenterologist or practitioner, read this.

Dear gastroenterologists and fellow practitioners,

I have deep respect for the work you do, and for the health systems, in the United States and internationally, that make it possible. I wrote this guide to make your work easier where I can, and to close a gap I see constantly: patients arrive with a bag of bottles and leave without having talked about them.

Most of your patients already use supplements. This guide organizes what they are taking into one reference: the exact product, the strength of the human evidence, the proposed mechanism, and the interactions worth knowing, built for the sometimes only fifteen minutes you have with a patient. Better communication between patients, gastroenterologists, primary-care clinicians, integrative practitioners, dietitians, and health coaches is the whole point.

I also want to help your patients understand and follow your advice. Adherence improves when people understand the plan and feel heard. I ask my clients to bring your recommendations to me, and I ask you to hear their questions and ideas with an open mind.

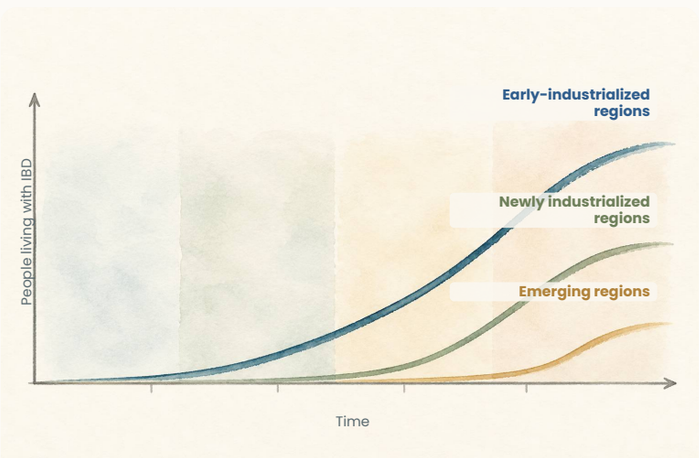
I share your concern about low-quality products, interactions with the medications you prescribe, and adverse effects. Every entry prints its additives and cautions, and I do not claim clinical validation for products that lack it.

This work follows the science, and the references are there so you can check me. I welcome any and all feedback.

With gratitude and respect,



Andrew Kornfeld · founder, Systema Health · health educator and health coach



Shaded stages, left to right: **1** emergence · **2** acceleration in incidence · **3** compounding prevalence · **4** prevalence equilibrium (proposed)

IBD prevalence has risen in every setting studied

A conceptual drawing of the four epidemiologic stages described by Kaplan and Windsor (2021) and Hracs et al. (2025). The curves are illustrative, not plotted data.

Reported prevalence, people per 100,000 (Hracs et al., *Nature*, 2025):

Olmsted County, US	120 in 1965 → 630 in 2019
Japan	67 in 2000 → 165 in 2016
Brazil	14 in 2000 → 100 in 2020

Prevalence is the number of people living with IBD at a given time; incidence is new diagnoses. These are selected settings, not a global average. Global estimates: 6.8 million people in 2017 (GBD 2017) and 4.9 million in 2019 (GBD 2019); the two rounds used different methods. (refs 196–200)



A

SECTION A · ENTRIES 1–5 · ALL FIVE WITH A PRODUCT

The Five

If someone with Crohn's disease or ulcerative colitis asked me where to start, this is the section, and these five are the answer I have given for a decade. They are my lowest-hanging fruit and my foundation: not necessarily the five with the most trials, but the five I would not build a regimen *without*. Curcumin and vitamin D carry the deepest randomized-trial records in the guide. Quercetin is the entry with the largest gap I know between the clinical evidence, which is thin, and what I have watched it do for people over a decade; both numbers are printed on its page so you can see the disagreement for yourself. Omega-3 fatty acids come with an enormous research background across cardiovascular, metabolic and inflammatory conditions; their IBD-specific trials are more mixed, and the entry keeps the two apart. Bovine immunoglobulins do a job nothing else here does, binding bacterial material in the lumen before it reaches the wall, which is why they matter most to people whose disease runs with diarrhea. Add them one at a time, on a stable foundation, and give each a fair trial.

Buy all five together in my Fullscript dispensary

go.supplementsforibd.com/the-five

Illustration: turmeric, red onion, omega-3 oil, immunoglobulin and sunlight

Never make changes to your protocol without consulting your gastroenterologist.

Section A · The Five

How to read the five entries



Each of the five entries runs three pages and follows the same order, so that once you have read one you can find your way around the others. It opens with the **exact product and form**: brand, strength, pack size, every additive on the label, and the link, because that is what most people came for. Then **what it is and how it works**, with the structure of the molecule drawn beside it. Then **the evidence, kept separate from my opinion**: the studies with the doses they used, an evidence bar for the human IBD data, and my own score printed next to it, never blended into it. Quercetin is the clearest case; its evidence bar says 2 beside my 5, and both numbers stay exactly where they are.

The last page of each entry covers **what to expect** and on what timescale, **who should be careful**, and **how it interacts with IBD medications**. My notes close every entry. They are labeled as opinion, and doses are reported only as the trials used them, never as a dose for you.

#	ID	Entry	Mechanism	Evidence
1	A-01	Curcumin	● Inflammation	5
2	A-02	Quercetin	● Inflammation	2
3	A-03	Omega-3 EPA/DHA	● Inflammation	4
4	A-04	Serum-derived bovine immunoglobulins	● Barrier	3
5	A-05	Vitamin D3	● Inflammation	4

Three that didn't make the Five

Glutamine, butyrate and creatine come up in almost every conversation about IBD supplements, and none of them is here. The reason is the same for all three, and it closes this section: they are fuel. Fuel is therapy too, just a different kind.

1 Curcumin

A-01

References 1–9

Diferuloylmethane · the principal curcuminoid of turmeric (Curcuma longa) · matched here as a phytosome (Meriva)

Primary: control inflammation | Secondary: barrier | Polyphenol | UC and Crohn's





Turmeric root / powder

Curcumin Phytosome (Meriva) NSF

Thorne · 120 capsules · verified on Fullscript, September 2026

Buy on Fullscript →

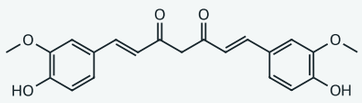
go.supplementsforibd.com/curcumin

Form	Curcumin bound to phosphatidylcholine (phytosome), capsules; 1 g curcumin phytosome per two capsules
Additives	Hypromellose capsule, leucine, calcium laurate, silicon dioxide, microcrystalline cellulose, flow agents and fillers, none on this guide's avoid list; disclosed because that's the rule
Why this one	A bioavailability-engineered curcumin with a large human safety record, NSF-certified, and the one I take myself. See the form note below for how it relates to the trial forms.
SKU	THO-SF814N

What I take: 1–3 capsules daily. That is what I personally do, not a dose for you, the label says 1–2 capsules twice daily, and your team should guide yours.

A second option: Theracurmin

The colloidal-dispersion form used in the Crohn's trial (Sugimoto 2020) is sold as Theracurmin, and it is a legitimate alternative: the trial was run on it. My caveats are its additive profile (magnesium stearate in two of the three licensed versions, plus the gum-and-dextrin carrier) and my impression that it costs more per day. Both work well for me; I would pick the phytosome. On Fullscript: **Integrative Therapeutics Theracurmin HP**, 60 caps, 600 mg per two, NSF, ITI-10630 (lists maltodextrin; see Section K): go.supplementsforibd.com/theracurmin



Curcumin, $C_{21}H_{20}O_6$, 368.4 g/mol. Two phenol rings joined by a seven-carbon chain with a β-diketone. Real structure; PubChem CID 969516.

What it is

Curcumin is the yellow pigment of turmeric root and the most-studied plant compound in inflammatory bowel disease. It has randomized trials in ulcerative colitis, a positive randomized trial in Crohn's disease, and a well-understood problem: on its own, almost none of it gets absorbed. The story of curcumin in IBD is therefore really two stories, what the molecule does once it reaches inflamed tissue, and how you get it there; every engineered curcumin exists to solve the second problem.

How it works

Curcumin sits upstream of much of the inflammatory cascade. It inhibits activation of **NF-κB**, the transcription factor that switches on TNF-α, IL-1β, IL-6, COX-2 and iNOS, the same signaling that anti-TNF biologics interrupt further downstream. It activates the **Nrf2** antioxidant response, and in colitis models it preserves tight-junction proteins and shifts the microbiome toward a less inflammatory composition. In the trials, the measurable effects were fewer relapses in patients already in remission, more patients reaching remission when added to mesalamine, and lower endoscopic activity.

The absorption problem is chemical: curcumin is nearly insoluble in water and is rapidly conjugated in the gut wall and liver, so dietary turmeric, even in generous amounts, produces blood levels close to

Category
Polyphenol (curcuminoid), herb-derived

Phenotype
Ulcerative colitis (most data); Crohn's disease (one positive RCT)

Other IBD
Indeterminate colitis: read the UC and Crohn's evidence as yours. Microscopic colitis: no trials; plausible on mechanism (NF-κB, TNF-α), untested.

Whole-food source
Turmeric root, but dietary curcumin is very poorly absorbed; food and supplement are not interchangeable here

Cross-references
C-02 boswellia (the other phytosome) · C-14 rutin and A-02 quercetin (fellow polyphenols)

zero. Every positive trial used either a high dose of plain curcumin (2–3 grams) or a bioavailability-enhanced form at a much lower dose.

Evidence 5

Multiple positive RCTs in UC (maintenance and induction) plus one positive RCT in Crohn's. Not unanimous: a low-dose trial was negative, and endoscopic remission is less consistent than clinical remission across the meta-analyses.

Andrew's score 5

Andrew's judgment, 1–5, labeled as opinion.

The evidence

Hanai et al., 2006 Clin Gastroenterol Hepatol · RCT, n = 89	Ulcerative colitis in remission, all patients on sulfasalazine or mesalamine. Curcumin 1 g twice daily (2 g/day) or placebo for 6 months. Significantly fewer relapses in the curcumin group (2 of 43, 4.65%, versus 8 of 39, 20.51%), with improvement in clinical and endoscopic indices. Rated low risk of bias by the Cochrane review that included it.
Lang et al., 2015 Clin Gastroenterol Hepatol · RCT, n = 50	Mild-to-moderate UC not responding to optimized mesalamine. Curcumin 3 g/day or placebo added for 4 weeks. Clinical remission in 54% of the curcumin group vs 0% on placebo; clinical response 65% vs 13%.
Sugimoto et al., 2020 J Crohns Colitis · RCT, n = 30	Active mild-to-moderate Crohn's disease, five Japanese centers. **Theracurmin 360 mg/day** (a colloidal-dispersion curcumin) or placebo for 12 weeks. Clinical remission 40% vs 0% at week 12; significant reduction in endoscopic severity; healing of anal lesions at week 8. No serious adverse events. The only RCT in Crohn's, and it used an engineered form.
Meta-analysis, 2024 Updated systematic review of RCTs in UC	Curcumin added to standard therapy roughly doubled the likelihood of clinical remission (risk ratio 2.33) and improved clinical and endoscopic response; endoscopic *remission* did not reach significance. Heterogeneity between trials was high, different doses, forms and durations.
Kedia et al., 2017 World J Gastrointest Pharmacol Ther · RCT, n = 62	Mild-to-moderate UC on mesalamine; 150 mg of plain curcumin three times a day (450 mg/day) or placebo for 8 weeks. No difference in remission (31% vs 27%), response or mucosal healing. Included because it is the clearest evidence that dose and form are not details; they are the whole question.

Dose as studied

Study	Form	Dose	Duration
Hanai 2006	Plain curcumin	2 g/day (1 g twice daily)	6 months
Lang 2015	Plain curcumin	3 g/day	4 weeks
Sugimoto 2020	Theracurmin	360 mg/day	12 weeks
Kedia 2017	Plain curcumin	450 mg/day (negative)	8 weeks

Reported as used in the trials named. Not a recommendation.

What to expect

In the induction trials, differences appeared by 4 weeks (Lang) and grew through 12 (Sugimoto); the maintenance benefit in Hanai was measured over 6 months. Stools may turn yellow-orange; mild nausea or loose stool is the common complaint at gram doses. Nothing in the trials suggested curcumin works fast enough to be a flare rescue.

Form, timing and bioavailability

Plain curcumin is roughly 1% absorbed, so the form is the whole question. Three engineered forms have human data: **phytosome** (curcumin bound to phosphatidylcholine, Meriva, the form matched above), **colloidal dispersion** (Theracurmin, the form in the Crohn's trial), and various nano- and micellar preparations. The phytosome has the largest human safety record across conditions, and in one pharmacokinetic study delivered roughly 29 times more curcuminoids than an equivalent unformulated dose.

The Crohn's RCT used a different engineered form, so the product above rides on comparable-delivery logic, not on that trial. Take it with food, and read the label: phytosome products list total complex weight and curcumin content separately.

Who should be careful

People with gallstones or bile-duct obstruction (curcumin stimulates bile flow); anyone on anticoagulants or antiplatelet drugs; pregnancy at supplemental doses. Relevant to IBD: curcumin chelates iron and may reduce iron absorption, worth knowing if you are iron-deficient, as many people with IBD are.

Interactions with IBD medications

Used *alongside* mesalamine and sulfasalazine in every UC trial without a problem. Inhibits CYP3A4 and P-glycoprotein in laboratory studies, so it could theoretically raise blood levels of **tacrolimus** and **cyclosporine**; tell your team if you take either. No known interaction with thiopurines, methotrexate, steroids or biologics. Additive bleeding risk with anticoagulants.

Andrew's notes

Curcumin is the supplement I am most comfortable recommending in IBD, and the one with the deepest trial record in both diseases. It has been used in Ayurvedic medicine for thousands of years, and the modern trials have largely confirmed what that tradition observed: well tolerated and helpful for a meaningful share of people, and many gastroenterologists agree. The caveats are modest but real: the form decides whether the dose does anything, and it can chelate iron and add to the effect of blood thinners.

2 Quercetin

3,3′,4′,5,7-pentahydroxyflavone · the most abundant dietary flavonol · onions, capers, apples, berries

Primary: control inflammation | Secondary: barrier | Secondary: nourish | Flavonoid | Both (preclinical)

A-02

References 10–15



Repair Guard

PERQUE · 90 tabsules · verified on Fullscript, September 2026

Form	Quercetin dihydrate 1,000 mg + pomegranate 60 mg + OPC 10 mg + magnesium 35 mg per tabsule
Additives	**None.**
Why this one	A full gram of quercetin with no fillers, flow agents or binders, rare in this category.
SKU	PER-131

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go.supplementsforibd.com/quercetin



Red onion, capers, apples

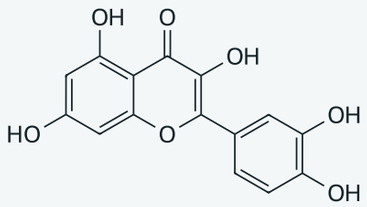
What it is

Quercetin is the workhorse flavonoid of the plant kingdom and one of the most-studied antioxidants in existence, in cells and in animals. In people with IBD, it has almost no direct trial evidence, and I want that stated in the first paragraph rather than the last. It is in the Five because of what I have seen in practice over a decade, and because the biology is unusually well matched to what goes wrong in this disease. The evidence bar below says 2. I have left it there.

How it works

Four properties matter. Quercetin is a **mast-cell stabilizer**: it reduces histamine release, which is why it is the flavonoid people reach for in allergy and mast-cell conditions, and why it is relevant to the histamine-type symptoms so common in IBD. It inhibits **NF-κB** signaling and lowers TNF-α and IL-6 in colitis models. It is an agonist at the **aryl hydrocarbon receptor (AhR)**, the same receptor activated by the microbiome's tryptophan metabolites, which is how it connects to the amino acid and microbiome sections of this guide; in a 2021 mouse study, quercetin's benefit in chronic colitis was AhR-dependent. And in models it raises tight-junction protein expression and increases colonic microbial diversity.

Like curcumin, it is poorly absorbed as the free aglycone, and like curcumin, that shapes which product is worth buying.



Quercetin, $C_{15}H_{10}O_7$, 302.2 g/mol. A flavonol: three rings, five hydroxyl groups. Real structure; PubChem CID 5280343.

Category
Flavonoid antioxidant

Phenotype
Both, on mechanism. Observationally, dietary intake tracks with lower UC risk but not Crohn's

Other IBD
Indeterminate colitis: read both. Microscopic colitis: no trials; the mast-cell mechanism is plausible, untested.

Whole-food source
Red onion, capers, apples (skin), berries, kale, buckwheat

Cross-references
C-14 rutin (quercetin's glycoside precursor) · I-01 tryptophan (AhR pathway) · H-07 DAO (histamine)

Evidence 2

No trial of supplemental quercetin in IBD as of this edition. Two 2024 prospective cohorts, one in people who already have IBD, link higher *dietary* quercetin intake to lower UC risk and to fewer surgeries and deaths; the scale counts dietary observation as a 2, not a 3, because it is not evidence about a supplement. Extensive animal-colitis data; randomized trials in other conditions.

Andrew's score 5

Andrew's judgment, 1–5, labeled as opinion.

The evidence

Lu et al., 2024 Food & Function · UK Biobank cohort, n = 187,709	Over 9.7 years, people in the highest quintile of dietary quercetin intake had 24% lower risk of developing IBD and 31% lower risk of ulcerative colitis (no association for Crohn's); parallel mouse experiments at physiological doses reproduced a protective effect. Observational: intake, not supplementation.
Wang et al., 2024 J Nutr · UK Biobank cohort of people already diagnosed with IBD	Among people with IBD, those in the highest quartile of dietary quercetin intake had less than half the risk of bowel resection surgery (hazard ratio 0.46) and roughly half the all-cause mortality (0.53) of the lowest quartile. Still observational, but it is the first human signal that quercetin tracks with hard outcomes in people who have the disease.
Mechanistic review, 2022 Biological activities underlying quercetin's effect in IBD	Summarizes the preclinical literature: barrier consolidation, increased colonic microbial diversity, restoration of local immune homeostasis, and reduced oxidative stress across DSS, TNBS and acetic-acid colitis models and in *Citrobacter* infection colitis.
AhR study, 2021 Mouse chronic DSS colitis, wild-type vs AhR-knockout	Quercetin and indole-3-carbinol improved chronic colitis in normal mice; the benefit was lost in mice lacking the aryl hydrocarbon receptor, direct evidence for the AhR mechanism.
Human RCTs, other conditions Adjacent evidence only	Randomized trials of oral quercetin exist in postmenopausal bone and inflammation (500 mg/day, 90 days), COPD (up to 2,000 mg/day, pilot), cardiac surgery inflammation, and other settings. They establish tolerability at these doses. None involved IBD.

Dose as studied

Setting	Form	Dose	Duration
IBD (human)	*No interventional trials*		
Postmenopausal RCT	Quercetin	500 mg/day	90 days
COPD pilot	Quercetin	2,000 mg/day	short-term

Animal doses are not translatable to people and are deliberately omitted. Not a recommendation.

What to expect

Because there are no IBD trials, there is no trial-level expectation to give you. What people describe (and what I have observed) is a reduction in histamine-type symptoms: flushing, itch, reactivity to certain foods, and the bloating that goes with them. That is observation, and it is labeled as such.

Form, timing and bioavailability

Free quercetin is absorbed poorly and variably (low single-digit percent in most studies). Absorption improves with food and fat. Phytosome preparations report substantially higher plasma levels than plain quercetin. Quercetin is very frequently co-formulated with bromelain (H-04) and vitamin C. The product above is a clean quercetin dihydrate at a full gram per tabsule, with no fillers at all, the reason it was chosen over the many quercetin products that carry three or four of the additives this guide warns against.

Who should be careful

Kidney disease (very high or intravenous quercetin has been associated with kidney injury historically); pregnancy and breastfeeding at supplemental doses; anyone with a history of hormone-sensitive conditions should discuss it, given quercetin's weak estrogenic activity in laboratory studies. **Thyroid disease**: in laboratory and rat studies quercetin reduced thyroid-cell growth, iodide uptake and thyroid function; there is no clinical trial of supplemental quercetin on the human thyroid, and one client of mine with a thyroid concern raised the question with me. That is one case and a laboratory signal, not a class-wide warning about polyphenols; if you have thyroid disease, put supplemental quercetin on the list you discuss with your team. (refs 201–203)

Interactions with IBD medications

Quercetin inhibits **CYP3A4** and **P-glycoprotein**, which can raise blood levels of **cyclosporine** and **tacrolimus**; this is the interaction to take seriously. Additive antiplatelet effect with anticoagulants. May reduce absorption of some quinolone antibiotics. No known interactions with mesalamine, thiopurines, methotrexate, steroids or biologics.

Andrew's notes

This is, hands down, in my opinion, the most powerful supplement for most people with IBD. That is a strong claim, I know it is a strong claim, and I am open to being wrong about it; it is also the entry with the largest gap between the quality of the research and what I actually see. Repair Guard is the most powerful version I know, and it carries a few companion compounds. Among my clients, roughly 90% have a very positive reaction, 5% neutral, 5% negative. What I see: one to three tabsules a day as maintenance, three to five in a flare, six in a very serious flare. The bottle allows up to twelve; I think that is far too high and would not do it. This is what I observe with clients, not a dose for you; work it out with your team.

3 Omega-3 EPA/DHA

A-03

References 16–21

Fish oil · eicosapentaenoic acid (EPA, 20:5 n-3) and docosahexaenoic acid (DHA, 22:6 n-3) · marine long-chain omega-3 fatty acids

Primary: control inflammation | Secondary: barrier | Lipid | UC stronger than Crohn's





Salmon, sardines, mackerel

ProOmega 2000, Lemon

Nordic Naturals · 60 softgels · verified on Fullscript, September 2026

Form Concentrated re-esterified triglyceride fish oil; 2,000 mg EPA + DHA per two-softgel serving

Additives Clean, no flow agents or additives on this guide's avoid list

Why this one Triglyceride form, high concentration so trial-range intakes take fewer softgels, third-party tested for oxidation and metals.

SKU NORD-12138

Buy on Fullscript →

go.supplementsforibd.com/omega-3

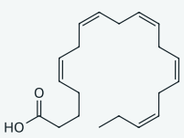
What it is

The two long-chain omega-3 fatty acids from cold-water fish are the most-consumed anti-inflammatory supplement in the world and one of the most-trialed in IBD, and the trial record is honestly mixed. The biology is not in doubt. The clinical question has always been dose, form, and which disease. The largest trials ever run, in Crohn's maintenance, were negative. Smaller trials in Crohn's and a recent well-designed trial in ulcerative colitis were positive. This entry tries to hold both facts at once.

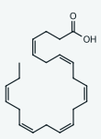
How it works

EPA and DHA are incorporated into cell membranes, where they displace the omega-6 fatty acid arachidonic acid. Arachidonic acid is the raw material for the most inflammatory prostaglandins and leukotrienes (PGE_2, LTB_4); EPA competes for the same enzymes and yields far less inflammatory products. More importantly, EPA and DHA are the precursors of the **specialized pro-resolving mediators** (resolvins, protectins, maresins) the molecules that actively switch inflammation *off* rather than merely failing to switch it on. They also signal through the GPR120 receptor on immune cells, lower TNF-α and IL-1β production, and in the UC trial below, brought down fecal calprotectin, the stool marker of neutrophils in the gut wall.

Membrane composition changes slowly, over weeks, which is why short trials and low doses tend to fail.



EPA, $C_{20}H_{30}O_2$, 302.5 g/mol. Twenty carbons, five *cis* double bonds. PubChem CID 446284.



DHA, $C_{22}H_{32}O_2$, 328.5 g/mol. Twenty-two carbons, six double bonds. PubChem CID 445580. Real structures.

Category
Lipid (polyunsaturated fatty acid)

Phenotype
UC (recent positive RCT); Crohn's maintenance (large trials negative, one small trial positive)

Other IBD
Indeterminate colitis: read both. Microscopic colitis: no trials.

Whole-food source
Salmon, sardines, mackerel, anchovies, herring; salmon roe. Plant ALA (flax, chia) converts poorly to EPA/DHA

Cross-references
F-08 phosphatidylcholine (membrane lipids) · J-13 vitamin E (protects oils from oxidation)

Evidence 4

Well-designed positive RCTs exist (Crohn's relapse, 1996; UC calprotectin and relapse, 2018), but the two largest trials (EPIC-1 and EPIC-2 in Crohn's maintenance) were negative. Results depend heavily on formulation and dose.

Andrew's score 4

Andrew's judgment, 1–5, labeled as opinion.

The evidence

Belluzzi et al., 1996 N Engl J Med · RCT, Crohn's in remission	An enteric-coated fish-oil preparation delivering 2.7 g/day of omega-3 free fatty acids, versus placebo, for one year. A 33-percentage-point absolute reduction in the one-year relapse rate, the landmark positive trial, and the one every later trial tried to replicate.
Feagan et al., 2008 JAMA · EPIC-1 (n = 374) and EPIC-2 (n = 379), Crohn's maintenance	Two large randomized, double-blind trials of 4 g/day omega-3 free fatty acids for up to 58 weeks. In EPIC-1, one-year relapse was 31.6% on omega-3 vs 35.7% on placebo, not significant; EPIC-2 was also negative. The authors' conclusion is unambiguous: omega-3 free fatty acids did not prevent relapse of Crohn's disease. This is the reason the evidence bar is not a 5.
Scaioli et al., 2018 Clin Gastroenterol Hepatol · RCT, n = 60, ulcerative colitis	Patients in clinical remission but with fecal calprotectin ≥150 µg/g (a marker of ongoing mucosal inflammation and a predictor of relapse). Highly purified EPA as free fatty acid, 2 g/day, or placebo for 6 months. Calprotectin fell significantly in the EPA group (p = 0.004); 6-month relapse-free survival was 76.7% vs 50%. A companion study showed EPA was incorporated into red-cell membranes and shifted colonic differentiation markers and microbiota.
Cabré et al., 2012 Br J Nutr · systematic review	Across the IBD trials, formulation varied, enteric-coated free fatty acids in most positive studies, non-coated ethyl esters in others, and trials that enrolled patients immediately after drug-induced remission tended to fail. A useful map of why the literature disagrees with itself.

Dose as studied

Study	Form	Dose (EPA + DHA)	Duration
Belluzzi 1996	Enteric-coated free fatty acids	2.7 g/day	12 months
Feagan 2008 (EPIC)	Free fatty acids	4 g/day (negative)	up to 58 weeks
Scaioli 2018	EPA free fatty acid, sustained release	2 g/day EPA*	6 months

*The trial registry and conference abstract report 2 g/day (two 500 mg capsules twice daily); the journal abstract lists "500 mg twice daily." Reported as used in the trials named. Not a recommendation.

What to expect

Slow. Membrane omega-3 content takes roughly 8–12 weeks to plateau, and the positive trials ran 6–12 months. The most useful marker to follow, if your team is willing, is fecal calprotectin, which is what the UC trial moved. Fishy aftertaste or "fish burps" usually mean an oxidized or low-quality oil, not a normal side effect of a fresh one. Loose stool at higher intakes.

Form, timing and bioavailability

Most fish oil on the shelf is in the **ethyl ester** form, which is cheap to concentrate and is not how omega-3s occur in nature. The **re-esterified triglyceride (rTG)** form is absorbed considerably better, the gap is largest when taken without a fat-containing meal, and shrinks with one. Take fish oil with your largest meal regardless. The trials used pharmaceutical free-fatty-acid and enteric-coated preparations that are not sold as supplements; a concentrated rTG oil is the closest consumer equivalent, and concentration matters because trial-range intakes (2–3 g/day of EPA + DHA) are impractical with dilute oils. Look for third-party testing for heavy metals and for oxidation (a published TOTOX value). Refrigerate after opening.

Who should be careful

Fish or shellfish allergy (most purified oils are tolerated, but ask); bleeding disorders; anyone with surgery scheduled should tell the surgical team. Large cardiology trials of high-dose omega-3 reported a small increase in atrial fibrillation, relevant if you have a heart-rhythm history.

Interactions with IBD medications

No known pharmacokinetic interactions with mesalamine, thiopurines, methotrexate, steroids, calcineurin inhibitors, JAK inhibitors or biologics. Additive effect with **anticoagulants and antiplatelet drugs**. May modestly lower blood pressure alongside antihypertensives.

Andrew's notes

Make sure it is the triglyceride form; the cheaper ethyl-ester concentrates are absorbed less well, especially without a fatty meal. Omega-3 matters most for people who do not eat much fish, and on the weeks I eat fish several times I take less of it. Its research background across cardiovascular and inflammatory conditions is enormous, while the IBD trials are more mixed, so I hold it as a foundation for the whole body rather than a lever I expect to feel from week to week.

4 Serum-derived bovine immunoglobulins

A-04

References 22–32

SBI · serum bovine immunoglobulin/protein isolate · an IgG-rich fraction of bovine plasma · sold as MegaIgG2000 (supplement) and EnteraGam (prescription medical food)

Primary: repair the barrier | Secondary: inflammation | Secondary: modulate | Biologic protein | Crohn's and UC



MegaIgG2000, capsules and powder

Microbiome Labs · 120 caps · 60 g powder · verified on Fullscript, September 2026

Buy on Fullscript →
go.supplementsforibd.com/bovine-immunoglobulin

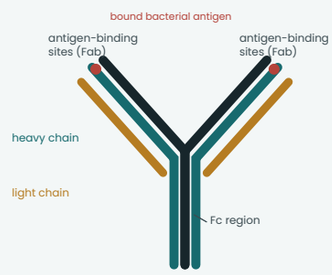
Form	Serum-derived bovine immunoglobulin concentrate; capsules (microcrystalline cellulose, cellulose capsule) or powder (**no additives**)
Additives	Capsules: cellulose only. Powder: none. Powder link: go.supplementsforibd.com/bovine-immunoglobulin-powder
Why this one	Dairy-free SBI as a supplement rather than a prescription; the powder makes the 5–10 g/day used in studies practical. Beef-allergy contraindication.
SKU	MIC630-18010475496 (caps) · MIC630-18015294856 (powder)

What it is

A concentrated preparation of antibodies (mostly immunoglobulin G) purified from the blood plasma of cattle, not from milk or colostrum, which is why it is dairy-free. It has been used for decades in animal nutrition and since the 2010s in people, first as a prescription medical food for chronic loose stools and then as a supplement. The IBD evidence is real but thin: a case series and case reports rather than randomized trials, alongside randomized trials in conditions that share IBD's leaky-barrier biology.

How it works

SBI is not absorbed. It works in the lumen, where the antibodies **bind bacterial components and toxins** (lipopolysaccharide, flagellin and others) and hold them away from the gut wall. The immunologist's term is *immune exclusion*: less microbial material reaches the epithelium and the immune cells beneath it, so there is less to react to. In an intestinal co-culture model, SBI bound pro-inflammatory bacterial compounds and prevented immune activation. In a randomized trial in HIV-associated gut damage, it lowered circulating markers of barrier injury (intestinal fatty-acid binding protein, zonulin) and of systemic inflammation (IL-6). In mice that spontaneously develop colitis, it had immunomodulatory effects on the colon. And in a recent study it shifted the gut microbiome toward a healthier profile, a prebiotic-like effect nobody expected from an antibody.



Immunoglobulin G, a ~150,000 g/mol protein: two heavy and two light chains in a Y, with two antigen-binding sites at the tips. *Schematic*, not a molecular structure; SBI is a mixture of antibodies with many specificities. No PubChem CID (biologic).

Category
Biologic protein (immunoglobulin concentrate)

Phenotype
Crohn's (most case-series patients) and UC; adjacent trials in IBS-D and HIV enteropathy

Other IBD
Indeterminate colitis: read both. Microscopic colitis: no trials, but binding luminal antigen and firming stool fits a watery-diarrhea disease better than most entries; the IBS-D data are the closest analogue.

Whole-food source
None practical. Colostrum (F-07) is the nearest food analogue but is a milk product with a different antibody profile

Cross-references
F-07 bovine colostrum · D-14 lactoferrin

Evidence 3

Retrospective case series and case reports in IBD; randomized trials only in adjacent conditions (IBS-D, HIV enteropathy). A pediatric IBD trial is registered. No randomized IBD trial yet.

Andrew's score 4

Andrew's judgment, 1–5, labeled as opinion.

The evidence

Shafran et al., 2015 Therap Adv Gastroenterol · retrospective case series, n = 45	Thirty-eight Crohn's and seven UC patients with limited or no symptom response to conventional therapy (including biologics) were given SBI 5 g/day as nutritional support alongside their regimens. At 12 weeks they were 2.8 times more likely to report clinical improvement in symptom scores (95% CI 1.27–6.02). Uncontrolled and retrospective, the largest IBD dataset that exists for SBI.
Liaquat et al., 2018 Am J Med Sci · refractory IBD	A second clinical series in patients with refractory IBD reporting improvement with SBI added to standard therapy.
Randomized trial, HIV enteropathy Double-blind, placebo-controlled; 103 completed	Adults on suppressive antiretroviral therapy with chronic diarrhea received placebo or SBI 2.5 g or 5 g twice daily for 4 weeks, then open-label SBI to 24 weeks. SBI significantly lowered I-FABP and zonulin (barrier damage markers) and IL-6, and raised CD4 counts in the lowest quartile. Not IBD, but the best controlled human data on SBI's barrier mechanism.
Wilson et al., 2013 Clin Med Insights Gastroenterol · RCT, n = 66, IBS-D	Six weeks of SBI at 10 g/day or 5 g/day versus placebo. The 10 g group had fewer days with abdominal pain, loose stools, bloating, flatulence and urgency; the 5 g group improved on flatulence, incomplete evacuation and any-symptom days. A pilot, analyzed within groups.
Soriano & Ramos-Soriano, 2017 Case report · pediatric UC	Clinical and histologic remission in a child with ulcerative colitis after SBI was added to the standard regimen. A single case, included because histologic remission is a hard endpoint and rare in the SBI literature.

Dose as studied

Study	Population	Dose	Duration
Shafran 2015	Refractory IBD	5 g/day	12 weeks
HIV enteropathy RCT	Chronic diarrhea on ART	2.5 g or 5 g twice daily	4 weeks blinded, 24 total
Wilson 2013	IBS-D	5 g/day and 10 g/day	6 weeks

Reported as used in the studies named. Not a recommendation.

What to expect

The Shafran series measured at 12 weeks; the IBS-D and HIV trials at 4–8. Stool consistency and frequency are what move first in every dataset. Well tolerated, SBI is a food protein, and the main complaints in trials were mild bloating early on.

Form, timing and bioavailability

Bioavailability is the wrong frame here: SBI is supposed to stay in the gut. What matters is **grams**. The studies used 5–10 g/day, and capsules add up fast at those amounts; the powder form (which mixes into water or food) is how most people reach study-range intakes affordably. Note that the capsule and powder labels state IgG content differently, verify against the current label before comparing. Taken with or between meals; some clinicians separate it from other protein-heavy meals so it isn't simply digested along with them, though this is practice, not evidence.

Who should be careful

Beef allergy, this is a bovine blood product. Also **alpha-gal syndrome** (tick-bite-acquired red-meat allergy). Dairy-free, so milk allergy and lactose intolerance are not an issue. Vegetarians and vegans will want to know what it is made from.

Interactions with IBD medications

None documented. Because SBI is not absorbed, pharmacokinetic interactions with mesalamine, thiopurines, methotrexate, steroids, calcineurin inhibitors, JAK inhibitors or biologics are not expected. In the Shafran series it was added on top of all of these.

Andrew's notes

This is the entry I value most for people whose disease runs with diarrhea, and it is the one in the Five that works in the lumen rather than in the tissue: the antibodies bind bacterial material and toxins before they reach the wall, which is the part of the loop that keeps the immune system provoked. I find it less relevant for people with severe constipation, where firming the stool is not the goal, though the binding rationale still applies. The same protein is sold in the US as EnteraGam, a prescription medical food for the dietary management of chronic diarrhea that must be used under medical supervision; that is a regulatory category, not proof that it treats IBD, and the supplement linked here is the form most people can actually get. (ref 207)

5 Vitamin D3

A-05

References 33–39

Cholecalciferol · the form made in skin from sunlight · measured in blood as 25-hydroxyvitamin D · often paired with vitamin K2, which has its own entry (J-15)

Primary: control inflammation | Secondary: barrier | Vitamin (secosteroid hormone precursor) | Crohn's stronger than UC





Sunlight; fatty fish, egg yolk

Vitamin D3 5,000 IU

Jarrow Formulas · 100 softgels · verified on Fullscript, September 2026

Form Cholecalciferol 5,000 IU (125 mcg) in extra-virgin olive oil, softgel

Additives Bovine gelatin softgel, glycerin, water, clean

Why this one Standalone D3 in an oil base, better absorbed than dry tablets when fat absorption is impaired, and no combination ingredients. Get a 25(OH)D test first; this is the one entry where the right amount is knowable.

SKU JAR-D5000

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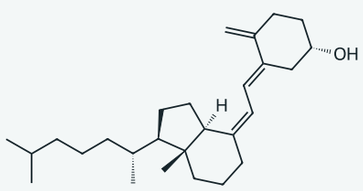
go.supplementsforibd.com/vitamin-d3

What it is

Vitamin D is less a vitamin than the precursor to a hormone, and its receptor is found on nearly every immune cell in the gut. Deficiency and insufficiency are extremely common in IBD, poor absorption, less sun, steroid courses, and inflammation itself all push levels down, and low levels track with higher disease activity, more hospitalizations and more surgery in observational studies. That much is settled. Whether *giving* vitamin D changes the course of the disease is the live question, and the randomized trials, pooled, lean toward yes in Crohn's disease.

How it works

The active hormone binds the **vitamin D receptor** on T cells and shifts the immune response away from the inflammatory Th1 and Th17 programs and toward **regulatory T cells** and IL-10, the immune system's brakes. In the epithelium, VDR signaling maintains **tight-junction proteins** (claudins, ZO-1) and induces the antimicrobial peptides cathelicidin and β-defensin, so the barrier is both tighter and better defended. It is essential for calcium absorption and bone, and bone loss is one of the most common complications of IBD, made worse by every steroid course. Magnesium is required for the enzymes that activate it, which is why the two are often considered together.



Cholecalciferol (vitamin D3), $C_{27}H_{44}O$, 384.6 g/mol. A secosteroid: a cholesterol skeleton with one ring opened by ultraviolet light. Real structure; PubChem CID 5280795.

Category
Fat-soluble vitamin

Phenotype
Crohn's disease in remission (strongest pooled effect on relapse); UC data limited

Other IBD
Indeterminate colitis: read both. Microscopic colitis: no trials; relevant for bone protection during budesonide, a corticosteroid, in a population that skews older.

Whole-food source
Sunlight on skin; fatty fish, cod-liver oil, egg yolk; fortified foods. Diet alone rarely corrects a deficiency

Cross-references
J-15 vitamin K (calcium partner) · J-05 magnesium (activation cofactor) · J-07 calcium

Evidence 4

Randomized trials in Crohn's show fewer relapses when pooled (three meta-analyses agree), but individual trials are small, the landmark trial just missed significance (p = 0.06), and a high-dose post-operative trial was negative. UC data are sparse.

Andrew's score 5

Andrew's judgment, 1–5, labeled as opinion.

The evidence

Jørgensen et al., 2010 Aliment Pharmacol Ther · RCT, 108 randomized / 94 analyzed	Crohn's disease in remission. Vitamin D3 1,200 IU/day (with 1,200 mg calcium) or placebo (calcium alone) for 12 months. Serum 25(OH)D rose from 69 to 96 nmol/L by 3 months. Relapse 13% (6/46) on vitamin D vs 29% (14/48) on placebo, p = 0.06, a halving of relapse that narrowly missed statistical significance in a trial that was too small. No hypercalcemia.
Systematic review with meta-analysis, 2024 Inflamm Bowel Dis · RCTs, 458 patients	Pooled risk of clinical relapse 0.64 (95% CI 0.46–0.89) with vitamin D supplementation across IBD; in Crohn's patients in clinical remission specifically, risk ratio 0.47 (0.27–0.82) with no heterogeneity. Only two UC studies (67 patients) were available, the UC signal is a gap, not a negative.
Two earlier meta-analyses, 2018 and 2020 Medicine; and a 2020 systematic review of 5 studies (n = 253)	Both reached the same direction: lower relapse with supplementation (the 2020 analysis reported an odds ratio of 0.33 with no heterogeneity), and no clear advantage of high-dose over low-dose regimens.
de Bruyn et al., 2021 Clin Gastroenterol Hepatol · Dutch-Belgian RCT, post-operative Crohn's	High-dose vitamin D (25,000 IU weekly) did not prevent post-operative recurrence of Crohn's disease. An important negative result: the benefit seen in medically maintained remission did not carry over to the post-surgical setting at this dose.

Dose as studied

Study	Population	Dose	Duration
Jørgensen 2010	Crohn's, remission	1,200 IU/day + 1,200 mg calcium	12 months
de Bruyn 2021	Crohn's, post-op	25,000 IU weekly (negative)	—
Trials pooled in meta-analyses	IBD	Roughly 1,000–10,000 IU/day	3–12 months

Reported as used in the trials named. Not a recommendation. Vitamin D dosing is normally guided by a blood test.

What to expect

Blood levels change over about 3 months; the relapse endpoints in the trials were measured at 12. You won't feel vitamin D working. The way to know is a 25(OH)D test, which is cheap, standard, and the single most useful lab in this entire guide, because vitamin D is the one entry where the right amount is knowable for you personally.

Form, timing and bioavailability

D3 (cholecalciferol) raises blood levels more effectively than D2 (ergocalciferol), the form still in some prescriptions. It is fat-soluble: take it with a meal containing fat. In Crohn's with ileal disease, bile-acid problems or steatorrhea, absorption of fat-soluble vitamins can be poor, and oil-based softgels or emulsified liquid drops are generally absorbed better than dry tablets. Because the correct amount depends entirely on your current level, this is the entry where "dose as studied" is least useful and a lab result is most useful.

Who should be careful

Hypercalcemia or hyperparathyroidism; a history of calcium kidney stones; sarcoidosis and other granulomatous diseases (which activate vitamin D outside the kidney and can push calcium up). Toxicity is real but is associated with sustained intakes far above anything in the trials above, the concern is prolonged very-high dosing without testing, not a normal supplement.

Interactions with IBD medications

Corticosteroids (prednisone, budesonide) impair vitamin D metabolism and accelerate bone loss, the interaction runs the other way: steroids raise the need. **Cholestyramine** (sometimes used for bile-acid diarrhea) blocks absorption; separate by several hours. Thiazide diuretics plus vitamin D can raise calcium. No interactions with mesalamine, thiopurines, methotrexate or biologics.

Andrew's notes

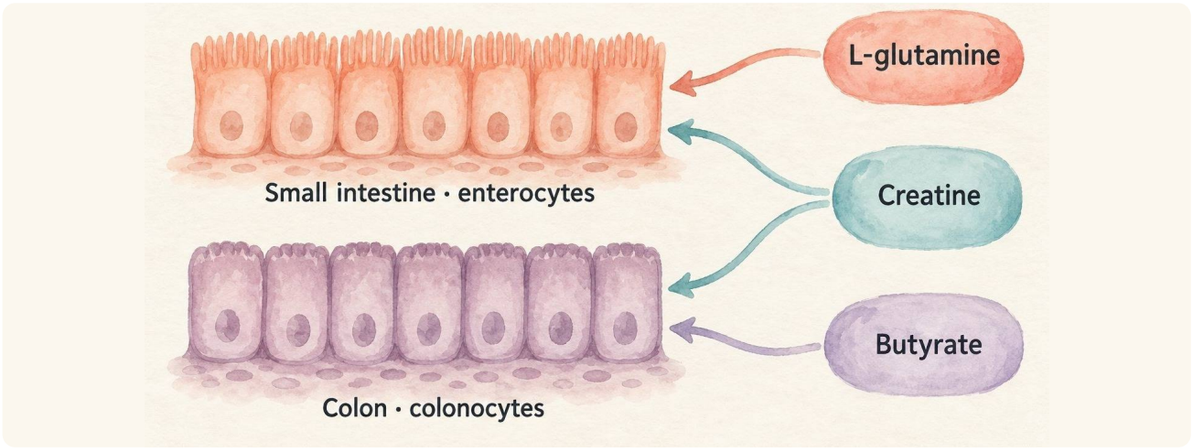
Many practitioners I respect aim for a blood level at the upper end of the normal range, and some use higher doses than the label to get there, under supervision and with repeat testing; the amount a given person needs depends on absorption, and a resection or active small-bowel disease changes it. Vitamin D is fat-soluble and excess is real: I have not personally seen toxicity, which is not evidence that it cannot happen. The rule I follow with my own level is the boring one: test, dose with your team, and retest.

Closing the Five

Fuel as therapy

Glutamine, butyrate and creatine: three of the most-discussed supplements in IBD, and why they are a different kind of therapy from the Five.

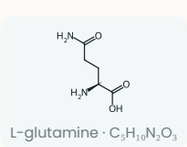
Before the barrier section, one idea that the Five kept circling without naming. Three of the most-asked-about supplements in IBD are not here, and it is not because they are weak. It is because they are a different kind of thing: they do not turn an inflammatory signal down or restore a missing microbe. They feed the cells that maintain and repair the gut lining.

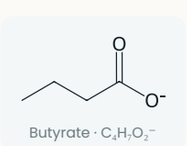


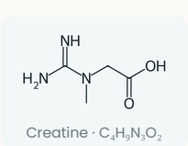
Fuel as therapy. Glutamine feeds the enterocyte of the small intestine, butyrate the colonocyte of the colon, creatine buffers ATP in both. All three have full product cards in Section F.

Three supplements didn't make the Five, and all for the same reason: they are fuel. **Glutamine** is the primary energy substrate for enterocytes, the cells lining the small intestine. **Butyrate**, a short-chain fatty acid produced when gut bacteria ferment fiber, is the primary energy substrate for colonocytes, the cells lining the colon. The two cell populations most affected in Crohn's disease and ulcerative colitis respectively run on two different fuels. **Creatine** is the third: a universal cellular energy buffer that operates in both. All three are inexpensive and widely available, which is part of why they come up so often. Full entries are in the barrier section.

Calling them fuel is accurate physiology, not a dismissal; fuel is therapy, just a different kind. A cell that is repairing itself under inflammatory stress has a higher energy budget than a resting one, and there is good evidence that the epithelium in active IBD is energy-starved, butyrate oxidation is impaired in inflamed colonic tissue, and the creatine-kinase system that buffers ATP in the gut lining is downregulated in active disease. Supplying substrate is a reasonable thing to do. It is just a different kind of thing from turning down NF-κB or restoring a missing bacterial species, and a guide that lumped them together would blur its own framework. A physiological role is not a proven supplement benefit; the Section F cards say where the human trials landed.


L-glutamine · $C_5H_{10}N_2O_3$


Butyrate · $C_4H_7O_2^-$


Creatine · $C_4H_9N_3O_2$

Where they live in this guide. Section F, Barrier Repair, opens with all three, each with a full product card; the butyrate card explains why form matters more for butyrate than for almost anything else here.

Fuel	Feeds	Relevance	Entry
L-glutamine	Enterocytes, small-intestinal lining	Crohn's (small bowel)	F-01
Butyrate	Colonocytes, colonic lining; also an HDAC inhibitor and GPR109A ligand	Ulcerative colitis (colon)	F-02
Creatine	Any cell with high ATP turnover, via creatine kinase / phosphocreatine, including gut epithelium	Both	F-03

Fuel · the product · link



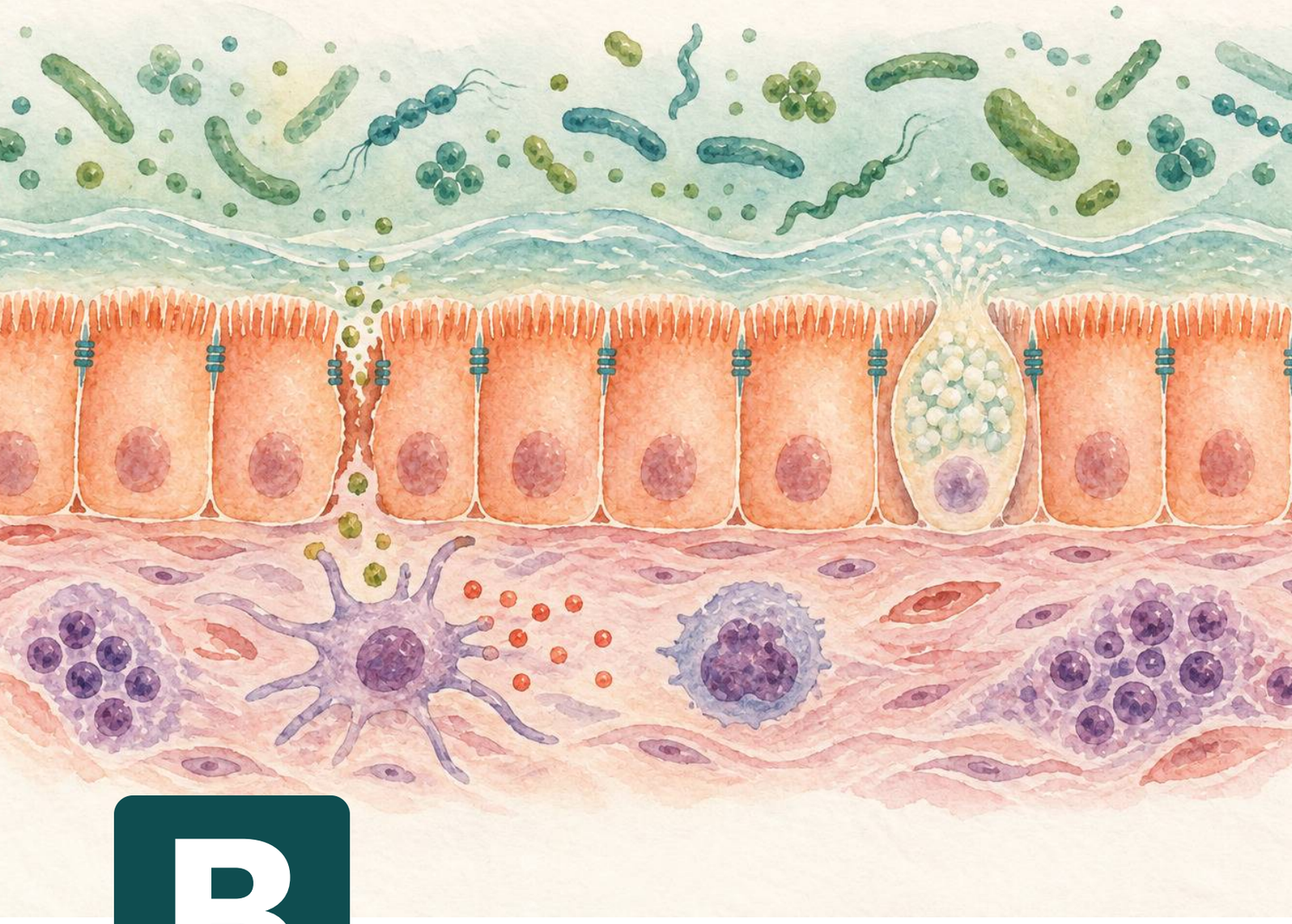
L-glutamine · F-01
Pure Encapsulations L-Glutamine Powder, 227 g · PUR-LGP · no additives
go.supplementsforibd.com/glutamine



Butyrate · F-02
Tesseract ProButyrate, 120 caps · TES617-GI000 · sustained-release butyric acid, allergen-free
go.supplementsforibd.com/butyrate



Creatine · F-03
Thorne Creatine, 450 g · THO-SF903 · monohydrate, no additives
go.supplementsforibd.com/creatine



B

SECTION B · TEN PAGES · THE SCIENCE UNDERNEATH THE GUIDE

Understanding How Supplements Work

This section is the science underneath everything else. You do not have to read it first: browse it now if you are curious, or come back to it when an entry uses a word you want explained. It opens with how I think about supplements and herbs at all, and the five rules I follow with my own: consider tapering as you feel better, consider carefully adjusting selected supplements if symptoms arise, check your liver enzymes, stay in close coordination with your team, and monitor how you actually feel. Then a little biology, and how to read the chemical drawings that appear beside the entries. Then the loop that keeps IBD turning: a disturbed microbiome provokes inflammation, inflammation loosens the barrier, a loosened barrier disturbs the microbiome further, and the disease runs as a cycle rather than a straight line. Then the five things a supplement can do inside that loop. Those five mechanisms are not the same as the Five in Section A; the Five are products, the mechanisms are jobs, and one product can do more than one job. The cytokines get a glossary of their own, because eight names come up on almost every page and it helps to know them as characters. Finally the gut wall itself, drawn in cross-section with every highlighted entry placed where it acts. The point of all of it is simple: when you and your team talk about a regimen, you should be able to say in one sentence what each bottle is for.

Illustration: the gut wall in cross-section, lumen above, immune tissue below

Never make changes to your protocol without consulting your gastroenterologist.

Section B · Understanding how supplements work

Why supplements at all? A philosophy

Before the mechanisms, the mindset. Here is how I think about supplements and herbs after a decade of taking them, studying them and watching them work and fall short in other people. What follows is my own interpretation of that experience, not a consensus.

They come third, and I mean it

Almost everything in this guide can be had, at least in part, from food. Turmeric and ginger in cooking, quercetin in red onions and capers, anthocyanins in a bowl of frozen blueberries, glycine and collagen in a pot of bone broth, butyrate from the fiber your own bacteria ferment, vitamin D from a walk in the sun. A dietary strategy is not the warm-up for a supplement plan; it is the plan, and a bottle is what you add when food and life cannot get you all the way there. One caution: the amount of a compound in a food and the amount used in a supplement trial are not automatically interchangeable, and the entries say which is which.

And yet: sometimes they are the deciding force

Here is what has changed my mind over the last few years. When a good medical strategy is in place, and a good dietary strategy is in place, I have watched supplements and herbs become the difference between remission and flaring. Not occasionally, and not only in people avoiding medication; in people on biologics and small molecules too. Something as unglamorous as a phytosome curcumin, a quercetin complex and a decent vitamin D level can be the margin that keeps a person on the right side of the line. That is why this guide exists, and why it takes the products so seriously.

Diversity beats intensity

IBD is not one signal; it is a crowd of them, TNF-α, IL-6, IL-1β, IL-17, IL-23, interferon-γ, leukotrienes, oxidative stress, and behind them a leaky wall and a disturbed microbiome. A biologic is a precision instrument aimed at one of those signals. Supplements and herbs are the opposite kind of tool: individually gentle, but between them they lean on many cytokines and many parts of the wall at once. The next page makes that argument in one picture, and this section ends with the gut wall drawn in cross-section so you can see where each entry lands.

Five rules I follow with my own

1. **Consider tapering as you feel better.** A regimen built for a flare is not a regimen for remission. When things are calm, I lower doses and drop what I no longer need, with my team's knowledge; some weeks, on a rest day, I take nothing at all. A body that runs well on less is the goal.

2. **Consider carefully adjusting selected supplements if symptoms arise.** At the first signs of trouble I adjust a few chosen doses (quercetin, curcumin, glutamine, bovine immunoglobulins) alongside, never instead of, the medical plan my team and I have agreed. A supplement can also make someone feel worse, and stopping it is an adjustment too. Which ones, and how far, is what "My personal protocol" in Section N is for; nothing here is an instruction to escalate on your own during a flare.

3. **Check your liver enzymes.** Herbs are metabolized by the same liver that handles your medications. Anyone taking several of them should have liver enzymes (ALT, AST, ALP, bilirubin) on their regular bloodwork, and should know what the numbers mean. A rising enzyme is a reason to stop and talk, not to push through.

4. **Stay in close coordination with your team.** Your gastroenterologist, your GP, your integrative practitioner, your dietitian, your coach: they should all know the full list, with doses. Bring the tracking sheet from Section N. A table is harder to dismiss than a bag of bottles, and it lets your team catch the interaction you did not know about.

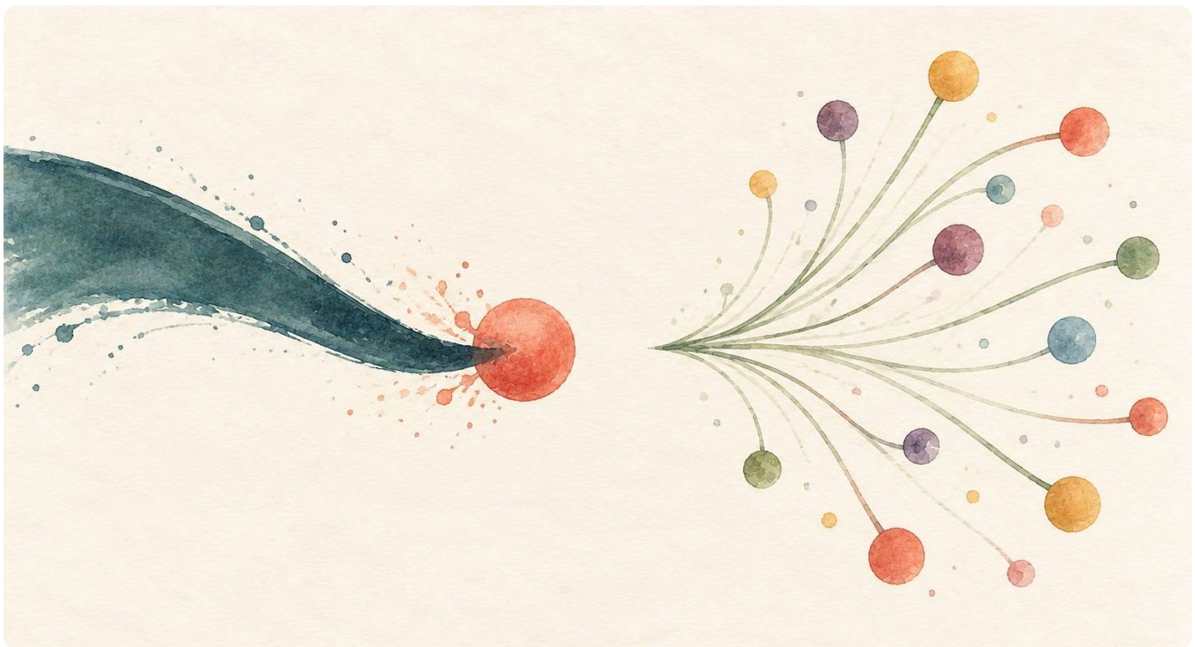
5. **Monitor how you actually feel.** Bowel movements, energy, sleep, pain, mood, and the labs that measure inflammation (CRP, fecal calprotectin). Add one thing at a time and write down what changes. The trials in this guide were designed one variable at a time; copy the design and you will learn what each bottle is really doing for you.



Section B · Understanding how supplements work

Diversity beats intensity

The whole argument for supplements and herbs in IBD, in one picture. A biologic is a precision instrument aimed at a single signal. A regimen is a crowd of gentle hands on many different levers at once.



One signal versus many. Left: a biologic, one thick stroke to one target. Right: a regimen, many thin strokes to many targets, none of them heavy.

IBD is not one signal. It is a crowd of them: TNF-alpha, IL-6, IL-1 beta, IL-17, IL-12 and IL-23, interferon gamma, the leukotrienes, oxidative stress, a barrier that leaks, a microbiome that has lost its calmest members. The great medications of the last twenty-five years work by choosing one member of that crowd and silencing it completely. Infliximab and adalimumab take TNF-alpha out of the room; ustekinumab takes IL-12 and IL-23; the JAK inhibitors cut the wire several cytokines share. That precision is their power, and it is also their limit: when a person's disease is being driven by a different member of the crowd, the drug that works so well for the next patient does nothing for them.

Supplements and herbs are the opposite kind of tool. Individually they are gentle; no polyphenol lowers TNF-alpha the way an antibody does. But a well-built regimen leans on many cytokines and many parts of the wall at the same time, and it can reach the levers no drug has been built for: the mucus layer, the tight junctions, the fuel supply of the colonocyte, the species that are missing from the microbiome.

This is why the mechanism tags on every entry matter, and why the capability matrix in Section N exists. When you build a regimen, choose entries that land in different places: something for inflammation, something for the barrier, something that feeds the microbiome, something that replaces what the disease has drained. Three anti-inflammatories that all act on NF-kappa B are less useful than one anti-inflammatory, one barrier repairer and one fiber.

It is also why this guide never asks you to choose between the two kinds of tool. The biologic buys time and quiet; the regimen works on the ground the biologic cannot reach. Most of the people I have watched do well over years are using both, with their medical team knowing exactly what is in the cabinet.

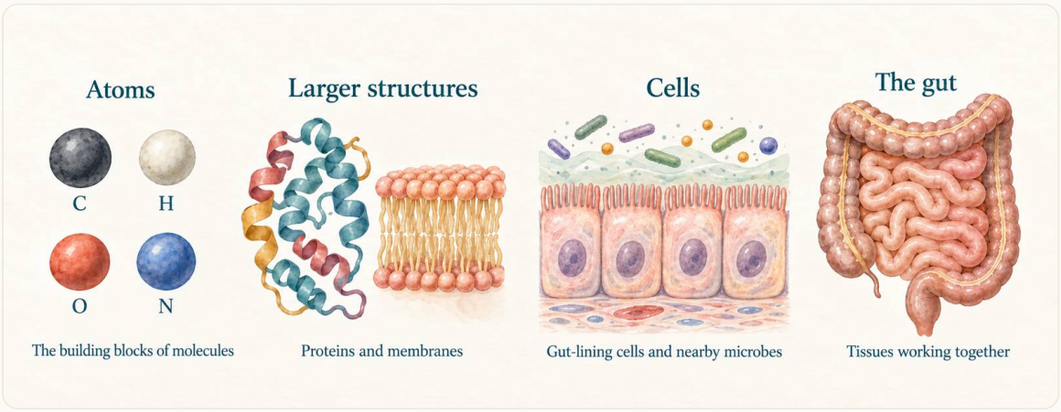
Where each entry lands

This section closes with the gut wall drawn in cross-section, "Where each mechanism lands," with every highlighted entry placed where it acts. "Meet the cytokines," a few pages on, names the crowd.

Section B · Understanding how supplements work

A little biology: from molecules to your gut

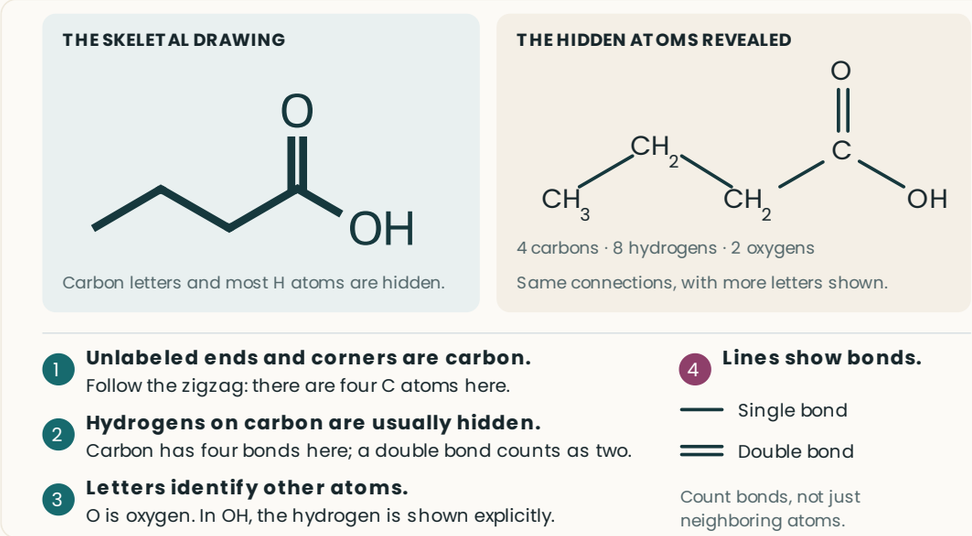
The entries in this guide talk about atoms, molecules, proteins, cells and microbes, and most of them carry a chemical drawing. Here is the background in pictures: how the scales fit together, and how to read the drawings.



Zooming out. These four views move up in scale; they are not a chain of chemical reactions. Atoms are the alphabet of the drawings: carbon, hydrogen, oxygen and nitrogen make up almost everything in this guide. Small molecules such as butyrate, glutamine and quercetin are short words in that alphabet. Proteins are very large molecules, and a membrane is an assembly built from lipids. Gut-lining cells sit in a single sheet with microbes living in the mucus just above them, and the intestines are those cells and their neighbors working together as tissue. A supplement may contain one molecule, a protein, a living organism or a mixture; the entries say which. Recognizing a structure tells you what a compound *is*, not whether it helps.

How to read a chemical structure

Example: butyric acid. This is the neutral acid drawn in the guide's butyrate entry (F-02): $C_4H_8O_2$, PubChem CID 264. The left panel is the drawing as it appears on the cards; the right panel is the same molecule with the hidden letters written in.



Chemical drawings use a compact visual language. An unlabeled end or corner of a line is a carbon atom. The hydrogens attached to carbon are usually left out, because in these ordinary neutral molecules carbon always has four bonds and you can fill them in yourself; a double bond counts as two. Other atoms are written as letters, O for oxygen and N for nitrogen, and an OH shows its hydrogen explicitly. One line is a single bond, two lines a double bond. Once you can read butyric acid, you can read every structure in this guide; the larger ones are only more of the same letters.

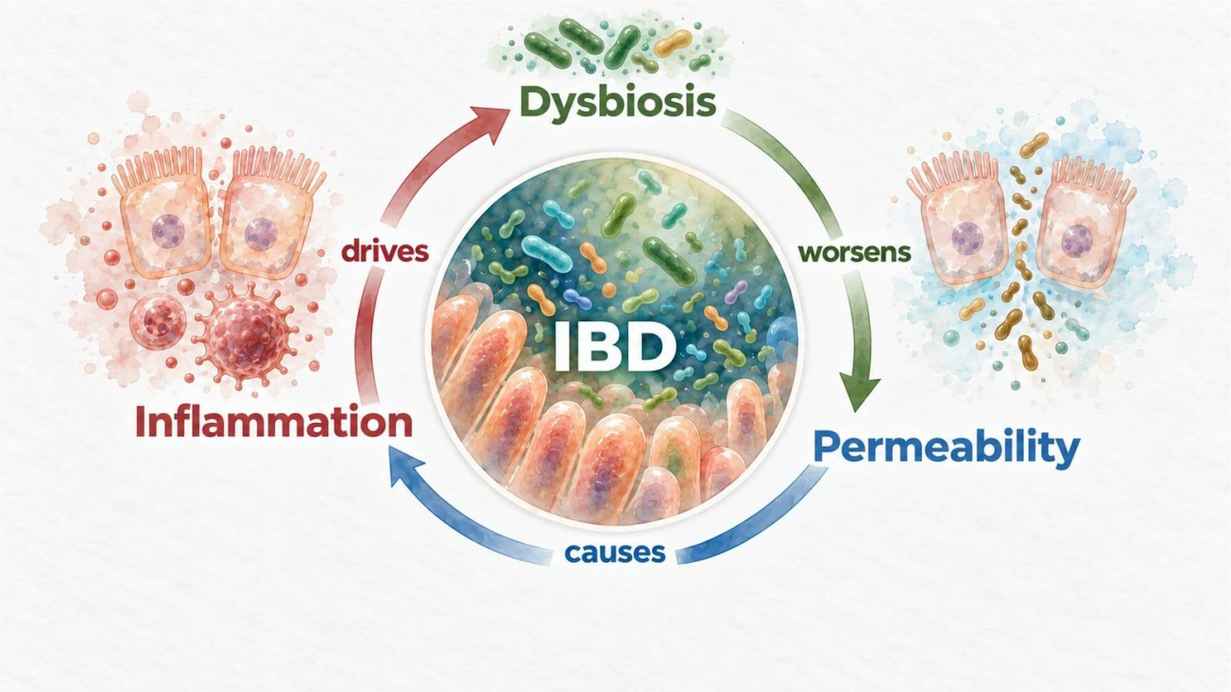
Butyric acid and butyrate. The drawing shows the acid. Butyrate is its related ion: the acid group has O^- in place of OH, and the minus sign marks an electrical charge. Sodium butyrate, the form in many products, adds a sodium ion to balance it. In the near-neutral conditions of the colon, butyric acid mostly exists as butyrate, which is why the two names are used almost interchangeably in this guide. The fuel page in Section A draws the ion; the F-02 card draws the acid; both are correct, and the caption on each says which.

Structure: the guide's F-02 drawing, verified against PubChem CID 264. Drawing conventions follow the IUPAC recommendations for skeletal formulas.

Section B · Understanding how supplements work

The loop that keeps IBD turning

Whatever your diagnosis, the disease runs as a cycle with three parts, and every supplement in this guide works by leaning on one of them.



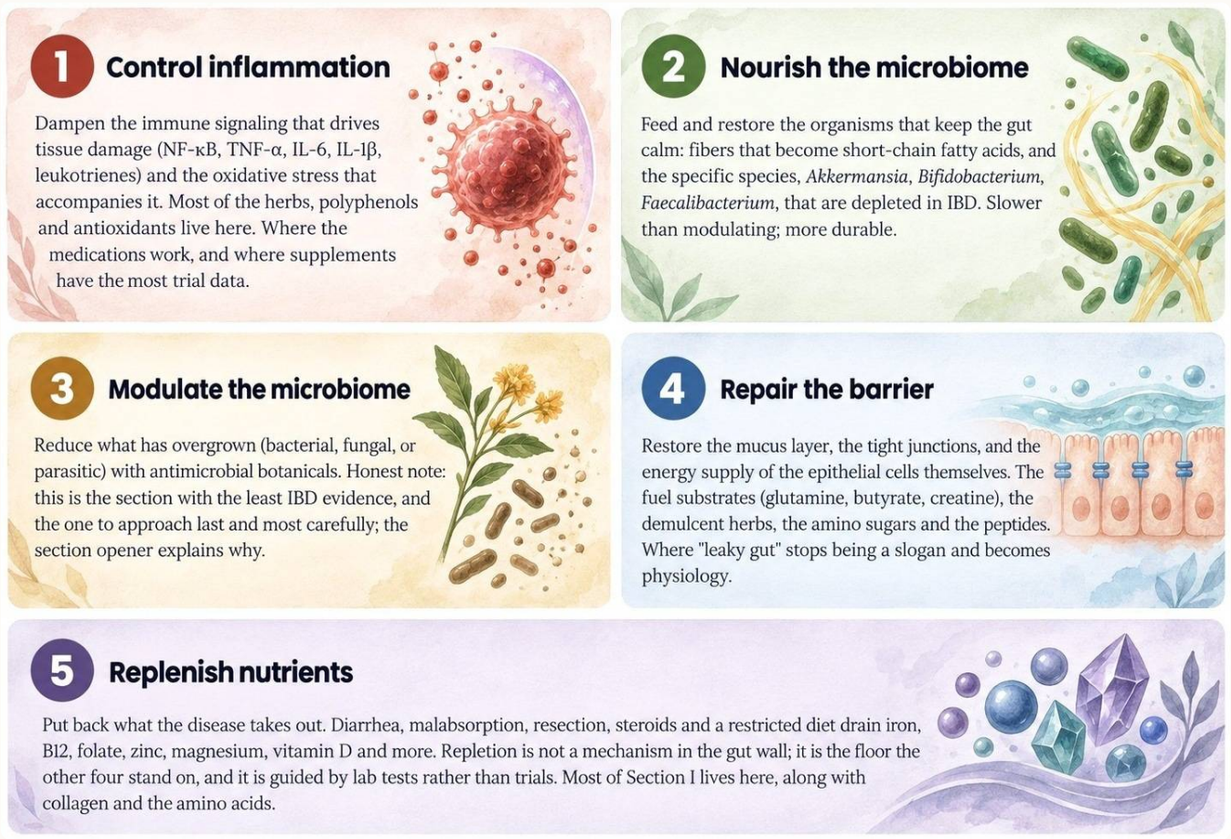
IBD runs as a loop. The immune system in the gut wall over-reacts. The microbiome has lost the species that keep it calm. The barrier of mucus and cells has become leaky, so more bacterial material reaches the immune system, and the loop turns again. A supplement helps by interrupting that loop somewhere, or by replacing what the disease has drained. The point of drawing it is to **intervene** in it rather than watch it, and every section that follows is a place to do so. The loop is the same in Crohn's, ulcerative, indeterminate and microscopic colitis; what differs is where in the wall it runs and which part dominates.

Dysbiosis is the microbiome losing the species that keep it calm and gaining the ones that provoke. **Inflammation** is the immune response in the wall, the part the medications act on. **Permeability** is the barrier letting through what it should hold back, which feeds the immune system more microbial signal. The arrows run one way on the page, but in the gut every part drives every other. That is why a single-mechanism regimen disappoints, and it is the one idea to carry into any conversation about a regimen: know which part of the loop each bottle is for.

Section B · Understanding how supplements work

Five things a supplement can do in IBD

Every one of the hundred entries is tagged with one primary mechanism from this list, plus any secondary ones. Learn these five and the rest of the guide organizes itself.



Two things follow. First, no single supplement addresses all five mechanisms, which is why a regimen built around one "miracle" ingredient disappoints. Second, **nourishing the microbiome matters more than modulating it**: killing what is overgrown is a shorter-term move than feeding what is missing. The 100 × 5 **capability matrix** in Section N shows every entry against every mechanism on two pages. It is the page to photograph.

Read the tags as verbs, and judge each entry by the measure its verb implies. An entry tagged **Inflammation** asks to be judged by CRP and fecal calprotectin over months, not by how the week felt; one tagged **Nourish** by tolerance and stool over weeks; one tagged **Barrier** by how the wall behaves under load; one tagged **Replenish** by a lab value and nothing else. Curcumin carries Inflammation first and Barrier and Nourish second, which is part of why it sits in the Five. Berberine is Modulate first, and its place in Section E rather than Section C tells you how to use it.

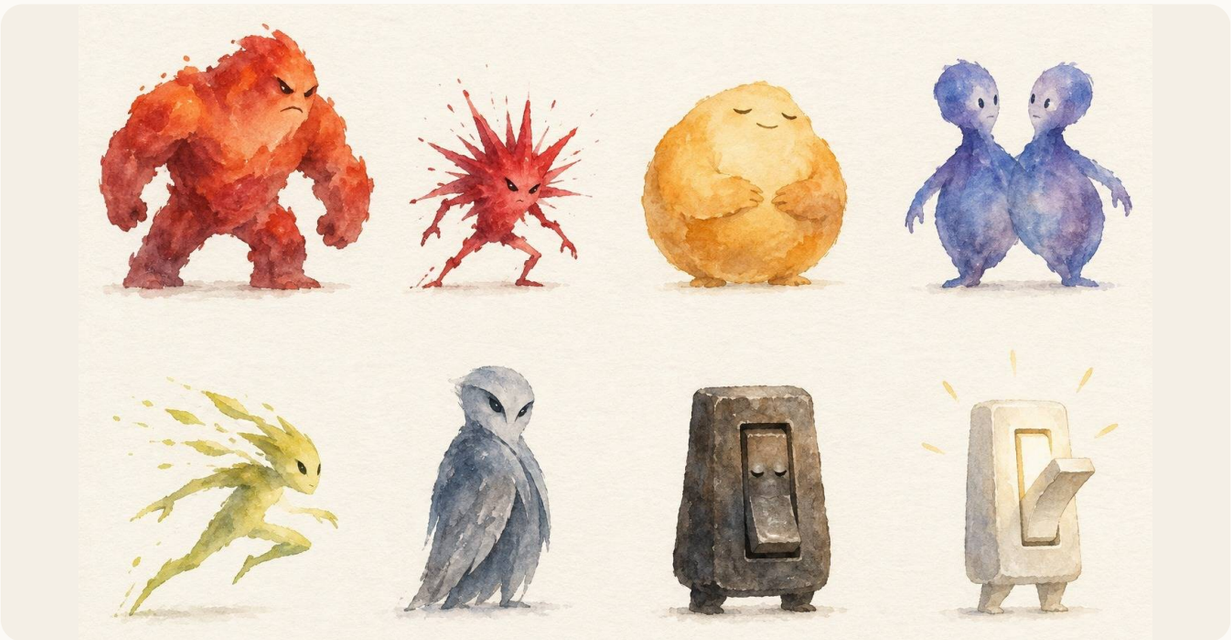
The first four are the four places you can interrupt the loop on the previous page: quiet the inflammation, feed the microbiome, thin what has overgrown, rebuild the wall. The fifth, repletion, is not a mechanism in the gut wall at all; it is the floor the other four stand on, and it is guided by lab tests rather than trials. Five mechanisms does not mean five products. Most people cover the ones that matter to them with two to four bottles, and knowing the categories is what lets you and your team see which job, if any, is uncovered.

When you build a regimen, cover the mechanisms before you cover the entries. Three anti-inflammatories that all switch off NF-κB are one move made three times; one anti-inflammatory, one fiber and one barrier repairer are three moves. The tags on every card are the shorthand, the section letters are the long form, and the matrix at the back is the whole board at once. If a regimen is not working, look for the mechanism nobody is covering before you add a fourth bottle to the one everybody is.

Section B · Understanding how supplements work · the glossary the whole guide leans on

Meet the cytokines

Eight names come up on almost every page of this guide. Here they are as characters, because that is how I remember them: the brute, the spark, the amplifier, the twins, the darter, the watcher, and the two switches that turn the whole cast on and off.



Left to right, top row: TNF-α, IL-1β, IL-6, IL-12/23. Bottom row: IL-17, IFN-γ, NF-κB (off), Nrf2 (on).

TNF-α

THE BRUTE

Tumor necrosis factor alpha is the loudest inflammatory signal in IBD: it recruits immune cells, opens tight junctions and drives the tissue damage you see on a colonoscopy.

Drugs: infliximab, adalimumab, golimumab, certolizumab. Entries that lean on it: curcumin A-01, boswellia C-02, wormwood E-04, KPV G-02, bilberry C-01.

IL-1β

THE SPARK

Interleukin-1 beta is the alarm that sets other cytokines off. It is released when the innate immune system meets bacterial material crossing the wall.

No IBD drug targets it directly. Entries: curcumin A-01, quercetin A-02 (via mast cells), melatonin C-08.

IL-6

THE AMPLIFIER

Interleukin-6 turns local inflammation into a systemic state: fever, fatigue, the raised CRP on your blood test, and the flat mood of a flare.

JAK inhibitors (tofacitinib, upadacitinib) block its signaling. Entries: curcumin A-01, mastic C-07, resveratrol C-06.

IL-12 / IL-23

THE TWINS

Two related messengers that steer naive T cells toward the aggressive Th1 and Th17 programs that keep Crohn's and UC turning.

Drugs: ustekinumab (both), risankizumab, mirikizumab and guselkumab (IL-23). Entries: vitamin D A-05 tilts this decision toward tolerance.

IL-17

THE DARTER

Interleukin-17 recruits neutrophils and defends the wall against fungi and bacteria. It is inflammatory, and it is also protective: blocking it made Crohn's worse in a trial.

A lesson in why 'lower every cytokine' is the wrong goal. Entries: vitamin D A-05, omega-3 A-03 shift the balance rather than blocking it.

IFN-γ

THE WATCHER

Interferon gamma is the Th1 signal that activates macrophages and, in the gut wall, damages the epithelium directly.

No approved direct blocker. Entries: bilberry C-01 lowered it in biopsies; omega-3 A-03 and vitamin D A-05 act upstream.

NF-κB

THE DARK SWITCH

Not a cytokine but the transcription factor that switches most of them on. Nearly every anti-inflammatory polyphenol in this guide works partly by keeping this switch off.

Entries: curcumin A-01, quercetin A-02, resveratrol C-06, boswellia C-02, cat's claw C-23, F. prausnitzii through its MAM protein.

Nrf2

THE BRIGHT SWITCH

The transcription factor that turns on the cell's own antioxidant and repair machinery: glutathione synthesis, detox enzymes, the resolution of inflammation.

Entries: sulforaphane C-15 is the classic activator; curcumin A-01, alpha-lipoic acid C-12, NAC C-10 and glutathione C-11 feed the same system.

The medications are named so you can see where the biologics and small molecules act; nothing here is a suggestion to change one. The entries named are the ones whose trials or mechanism studies touch that signal; the full picture for any entry is on its own page.

Section B · Understanding how supplements work · the glossary, continued

The good guys

Not every cytokine is a villain. Three of them keep the peace, tend the soil and rebuild the wall, and a surprising number of the entries in this guide work by helping them rather than by fighting the others.



Left to right: IL-10, TGF-β, IL-22.

IL-10

THE PEACEMAKER, AND THE SUPERHUMAN

Interleukin-10 is the signal that tells the immune system to stand down. It suppresses TNF-α, IL-1β and IL-6, calms macrophages and keeps regulatory T cells in charge. Children born without a working IL-10 pathway develop severe, very early IBD, which is the clearest proof there is of what it does.

Drugs: none has succeeded directly, though several probiotic strains and F. prausnitzii raise it. Entries: butyrate F-02, vitamin D A-05, the multi-strain probiotics D-04, curcumin A-01 in trials that measured it.

TGF-β

THE GARDENER

Transforming growth factor beta plants tolerance: it steers T cells toward the regulatory kind and drives the repair of tissue after injury. It has a dark side, laying down scar tissue and stricture when it runs too long.

No drug in IBD; too central to block. Entries: bovine colostrum F-07 supplies it directly; vitamin D A-05 and butyrate F-02 favor the regulatory program it runs.

IL-22

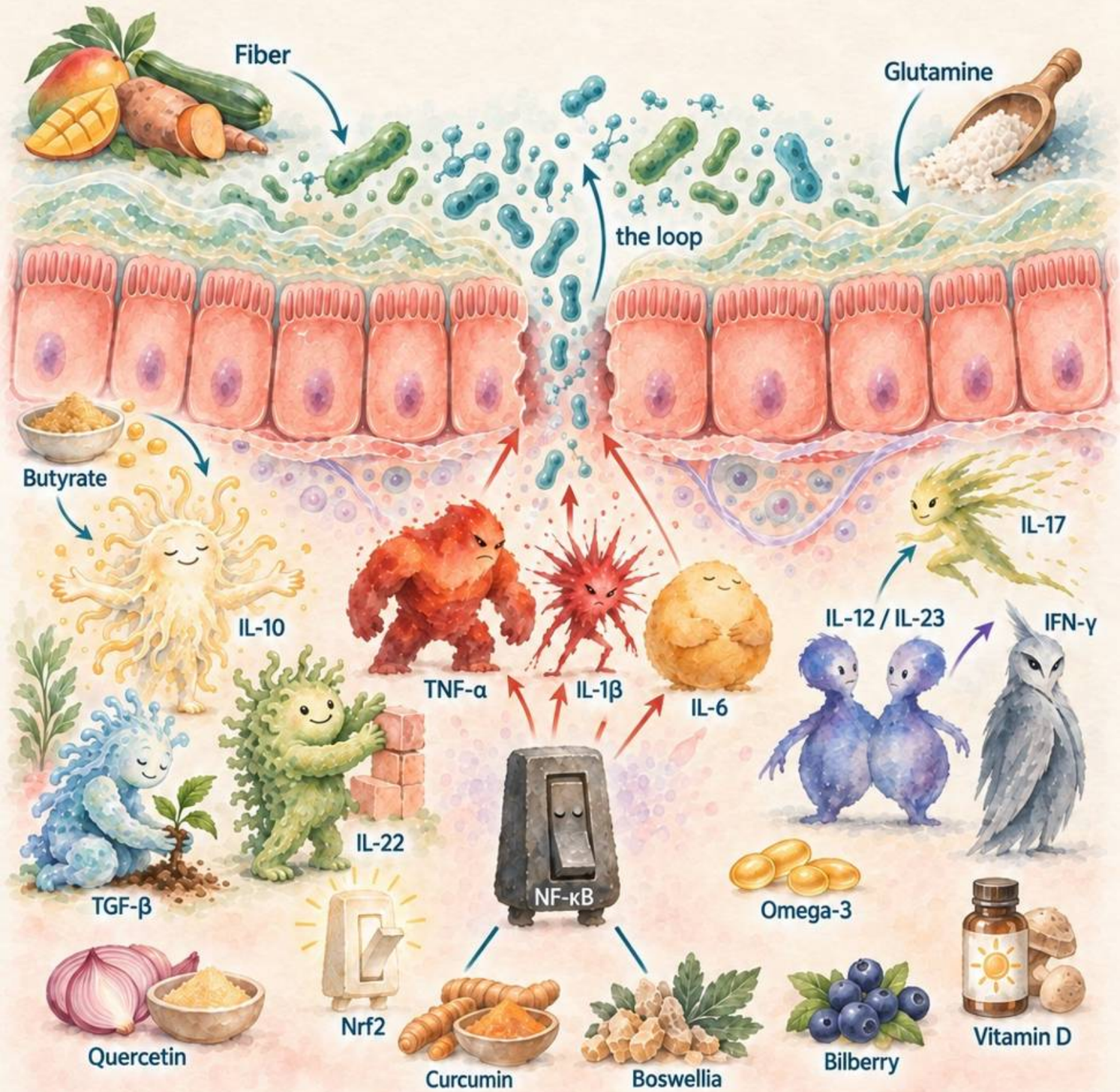
THE REPAIRER

Interleukin-22 speaks to the epithelium itself: it tells the wall to proliferate, to make antimicrobial peptides, and the goblet cells to make more mucus. It is one of the few cytokines whose job is mostly to rebuild.

Under study as a drug. Entries: indole compounds from tryptophan I-01 and the fibers of Section D raise it through the aryl hydrocarbon receptor; that is part of why fiber heals.

The lesson of this spread: "lower every cytokine" is the wrong goal. Blocking IL-17 made Crohn's worse in a trial; a gut with no IL-10 is a gut with severe disease from infancy. The supplements and herbs that help most tend to shift the balance toward these three rather than silencing the crowd on the previous page.

How the cytokines interact



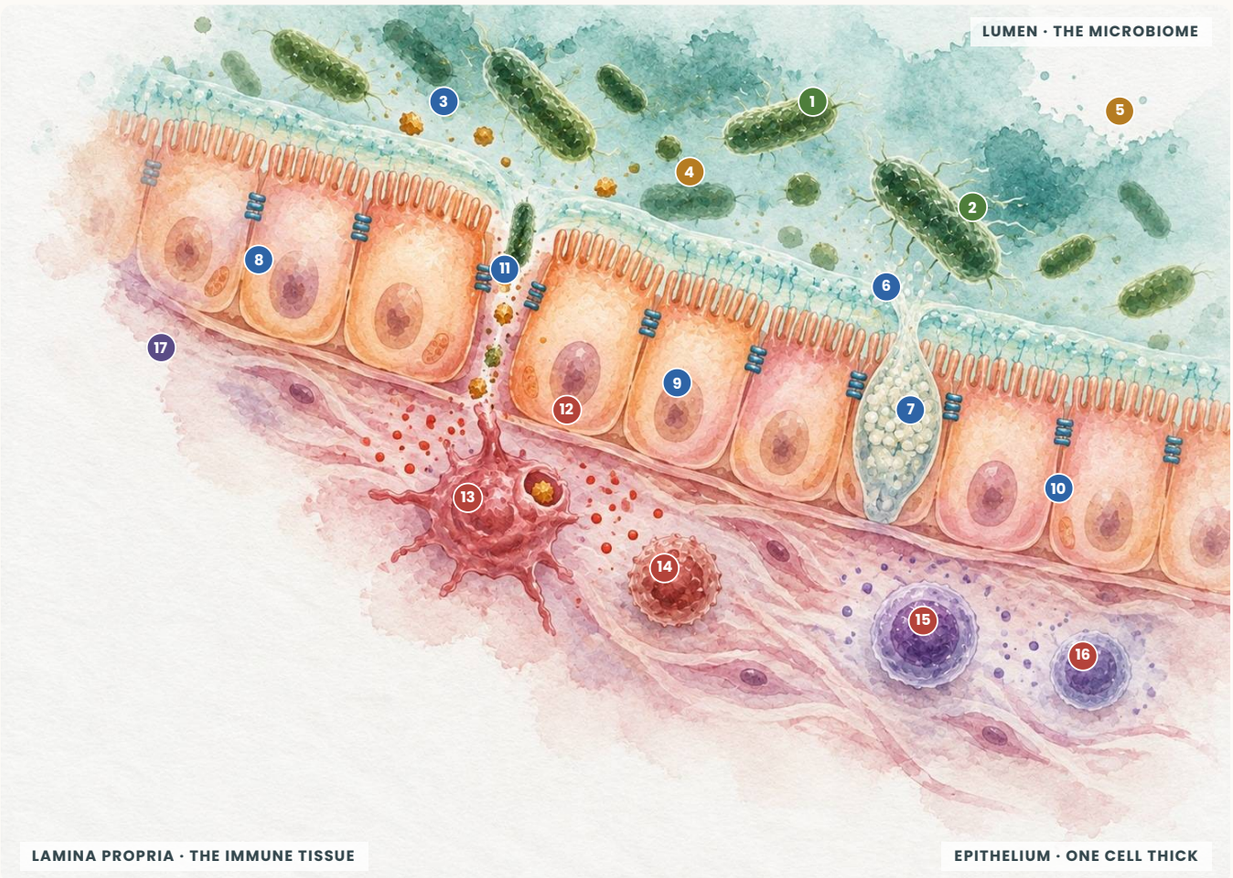
The glossary's cast returns in one simplified scene at the gut wall. Bacterial material crossing a loosened barrier wakes NF-κB, the dark switch, which releases TNF-α, IL-1β and IL-6; the red arrows show that inflammatory signaling reaching back up to the epithelium and opening it further, so more material crosses and the loop turns. To the right, IL-12 and IL-23 steer T cells toward IL-17 and IFN-γ. To the left, IL-10 tells the crowd to stand down, TGF-β plants tolerance and IL-22 tells the wall to rebuild. NF-κB and Nrf2 are transcription factors, drawn as switches, not cytokines. The ingredients around the edge are examples from this guide placed near the part of the picture their studies touch; fiber-containing foods sit above the wall with butyrate drawn separately, because your bacteria make butyrate from fiber. Icons and connectors are teaching metaphors, not a complete pathway, and none of them is evidence that a product works.

Never make changes to your protocol without consulting your gastroenterologist.

Section B · Understanding how supplements work

Where each mechanism lands

The cross-section from the opener of this section, now labeled: the lumen and its bacteria above, the mucus layer, the single-cell-thick epithelium sealed by tight junctions, and the immune tissue beneath. Seventeen markers show where entries in this guide actually act; everything in the nine sections is a variation on one of these moves.



1 Feed the residents
Psyllium D-07, inulin D-09, PHGG D-08, resistant starch D-11: fiber becomes butyrate

2 The mucus dwellers
Akkermansia D-01 lives in and turns over the mucus; probiotics D-02, D-04

3 Bind toxins in the lumen
Bovine immunoglobulins A-04 hold bacterial toxins before they touch the wall

4 Thin the overgrowth
Berberine E-01, oregano E-02, wormwood E-04: the modulators, used carefully

5 Digest, then relax
Enzymes H-02, papain H-03, bromelain H-04; peppermint H-01 for cramping

6 The mucus layer itself
Phosphatidylcholine F-08 is its main phospholipid; demulcents F-10, F-12 coat it

7 The goblet cell
Mucus is built from N-acetylglucosamine F-06; butyrate F-02 signals it to make more

8 Fuel the small-bowel cell
Glutamine F-01 is the enterocyte's preferred fuel (Crohn's)

9 Fuel the colon cell
Butyrate F-02 powers the colonocyte and quiets HDAC signaling (UC)

10 Buffer the energy supply
Creatine F-03 keeps the epithelium's ATP topped up under stress

11 The breach
Where junctions open: quercetin A-02, zinc-carnosine F-05, BPC-157 G-01, curcumin A-01

12 The cytokine spray
Polyphenols catch it: bilberry C-01, resveratrol C-06, green tea C-04, glutathione C-11

13 The dendritic cell
Vitamin D A-05 tilts antigen presentation toward tolerance

14 The macrophage and TNF-α
Curcumin A-01, boswellia C-02, wormwood E-04, KPV G-02 quiet the loudest signal

15 The lymphocytes
Omega-3 A-03 and vitamin D A-05 shift T-cell balance; melatonin C-08 acts here too

16 Resolution
EPA and DHA A-03 become the resolvins that switch inflammation off

17 What crosses into you
Iron, B12, zinc, magnesium, D (Section J): absorption falls when this wall is inflamed

Now that you've met the Five

How to read the rest of this guide

One hundred entries in nine sections, two numbers on every entry, a product for almost all of them, and the reference sections behind them. Here is the map.

The 100

After the Five come four sections organized by *what a supplement does in the gut*, **Anti-Inflammatories**, **Microbiome Nourishing**, **Microbiome Modulating**, **Barrier Repair**, and four organized by *what it is*: **Peptides**, **Digestive Support**, **Amino Acids**, **Vitamins & Minerals**. Within each section, the entries I'd actually buy get a full product highlight card: photo, brand, link, a short brief, both scores. Every other entry is in the section's list, linked where a clean product exists.

Who this is for

Written for people with IBD first, but also for the clinicians who care for them: gastroenterologists, GPs, integrative practitioners, dietitians and health coaches. Patients will find the products and plain-language briefs; clinicians will find the study tables, doses as studied, and interaction notes. It is for everyone in the room.

Two numbers on every entry

A **display number** (1–100, its position in this edition) and a **stable ID** like **C-08** that never changes. Talk about entries by ID; the display numbers will shift as editions change.

Two scores on every entry

The **evidence score** is about human IBD data specifically, on the fixed scale at right. **Andrew's score** is my own judgment, 1–5, what I've seen work over a decade in the IBD community, labeled as opinion, never blended into the evidence. Where the two disagree you'll see it. Generally my score runs a little higher than the evidence. That is a reflection of the field: research on supplements is not well funded, and there is far less of it than there is on the efficacy of medications, so a low evidence score often means "not yet studied" rather than "studied and failed." **A dash in my score** means I have not formed a personal opinion about that entry yet. It is not a zero, not a rejection, and not an evidence score. The vitamins and minerals in Section J carry a dash for a different reason: when a nutrient is being replaced because a lab test says it is low, my opinion does not belong in the decision.

Doses

Reported **as used in the studies**, never as a suggestion for you. Where I mention what I personally take, it is labeled as exactly that, and it is not a dose for anyone else.

The evidence scale

5 Multiple randomized controlled trials in IBD patients, consistent positive results

4 At least one well-designed positive RCT in IBD

3 Open-label, pilot, or observational study of the supplement itself in people with IBD

2 RCTs in adjacent conditions only (IBS, general inflammation), or observational data on dietary intake in IBD; no trial of the supplement in IBD

1 Preclinical only (animal models, in vitro)

A 1 is not a reason to leave something out. Preclinical evidence is legitimate; a low score is information, not a verdict. Quercetin (A-02) is the case that shaped the wording of the 2: two large cohorts link dietary quercetin to better outcomes in IBD, and no one has yet trialed the supplement.

Evidence 3

Example: open-label or pilot data in IBD.

Andrew's score 4

Example: my judgment, a notch above the evidence.

What comes after the 100

Buying Well (Section K) is about labels, additives and how the dispensary works. **Beyond the Hundred** (L) holds the honorable mentions I am still exploring, the things people ask about that didn't make the cut, and a note on enemas. Then a **bonus section** (M) on sleep, stress and attention, five products that are not IBD supplements but that I have come to think of as part of the picture. And **Building Your Regimen** (N) closes the guide: how to stack and sequence, interactions with IBD medications, the four questions, my own protocol and why, and the capability matrix.

The links, and how I choose brands

Every product link in this guide is a short link of the form go.supplementsforibd.com/<product>. Each routes to that exact product in my Fullscript dispensary. I earn a commission; you pay Fullscript's price. US shipping only. I choose products one at a time, not brands wholesale: recommending Microbiome Labs' bovine immunoglobulins is not a recommendation of the same company's spore probiotic, which I advise against. Companies get bought and formulas change, so I keep checking, and the newest edition of this guide is the one to trust. Section K explains the vetting in full; if you prefer another well-tested brand of the same ingredient, that is a reasonable choice.

Who this is for

Four diseases, one guide

"IBD" is four diagnoses, not two, and this guide is written for all of them. Where an entry's evidence comes from one disease and not another, the entry says so.

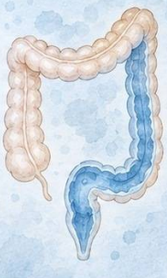
Crohn's disease

Can affect any part of the digestive tract, mouth to anus, and inflames the full thickness of the wall; it skips segments, scars and can fistulize. Most of this guide's *maintenance* evidence, omega-3 and vitamin D especially, was generated in Crohn's.



Ulcerative colitis

Confined to the colon and rectum, continuous from the rectum upward, limited to the inner lining, and almost always bloody. The curcumin, anthocyanin, butyrate and probiotic evidence is strongest here.



Indeterminate colitis

Also called IBD-unclassified: colitis that, even after biopsy, cannot yet be confidently called Crohn's or UC. It is common at first diagnosis, more so in children, and is often reclassified as the picture clarifies. Read both the UC and the Crohn's evidence as potentially yours; the five mechanisms are identical.



Microscopic colitis

Two subtypes, *collagenous* and *lymphocytic*, told apart only under the microscope. The colonoscopy looks normal, the diarrhea is watery and not bloody, and it skews toward adults over sixty and, for the collagenous form, toward women. Almost none of this guide's trial evidence was generated in it, which is why the note below exists.



If your diagnosis is microscopic colitis, read this before anything else

The evidence bars in this guide were earned in Crohn's and ulcerative colitis, and they do not transfer automatically. Mesalamine, a mainstay of UC, is not recommended over budesonide in MC by the AGA. Exactly one entry has been tested in your disease: **Boswellia (C-02)**, in a small placebo-controlled trial in collagenous colitis, produced remission in 64% versus 27% per protocol, a result that did not hold on intention-to-treat analysis. Everything else here is plausible on mechanism and untested in MC, and the entries say so where it matters.

Two things belong to your gastroenterologist rather than to this guide, and I mention them only so you know to ask. Budesonide is first-line treatment, it works well, and nothing in these pages replaces it. And microscopic colitis can be triggered by common medications, PPIs, NSAIDs and SSRIs among them, and travels with celiac disease and bile-acid malabsorption; a medication review and a celiac screen are worth requesting if they haven't happened.

Where I would still start: **the Five**, for the same reasons they lead the guide, safe, broad and mechanism-based, with the honest caveat that in MC they are untested rather than proven. Then **A-04**, because binding luminal antigen and firming stool fits a watery-diarrhea disease better than most entries. Then **A-05**, because budesonide is a corticosteroid and bone protection matters in a population that skews older. Then **C-02**. The probiotics in Section D are the one group I would hold back on: the AGA suggests against them for inducing remission in MC. (refs 173–176)

Before supplements

Diet first. Medicine when it's needed. Then this.

Supplements don't work on top of a diet that's feeding the fire, and they are not a substitute for a good gastroenterologist. Both of those sentences are load-bearing.

Diet is the foundation

There is no one diet for IBD. There is, however, no version of this disease in which diet doesn't matter, it is the foundation everything else in this guide sits on, and it is the thing I would work on before I bought a single bottle. Several dietary approaches have been successfully modified to work in IBD, and I've watched each of them change lives:

- **The Specific Carbohydrate Diet (SCD)**, the grandparent of IBD diets, with a growing trial base in pediatric Crohn's.
- **The IBD Anti-Inflammatory Diet (IBD-AID)**, developed at the University of Massachusetts, a phased, whole-food, prebiotic-rich approach built specifically for this disease.
- **Paleo AIP, modified**, the autoimmune protocol, adapted for the realities of a sore gut.
- **The Mediterranean diet**, the pattern with the broadest general-health evidence, and a randomized trial in Crohn's disease in which it performed comparably to the Specific Carbohydrate Diet. (ref 209)

The best single resource I know for going deeper is **Nutritional Therapy for IBD** (ntforibd.org), a nonprofit that does this one thing well. A companion diet document is planned; the newest version of this guide at supplementsforibd.com will link to it when it exists.

The order of operations

A medical team you trust first, with medication when the disease needs it. Then diet, mindset and the rest of the foundation. Then supplements, one at a time, on that stable foundation, so you can tell what each one is doing. Started in that order, supplements do real work. Started out of order, they mostly disappoint.



On medicine, and on your gastroenterologist

I want to be unambiguous about this, because a guide full of herbs can be read the wrong way. **I strongly support working with a good gastroenterologist, and using medication when it is deemed necessary.** Untreated inflammation in IBD is silently destructive; feeling better is not the same as being better, and only your team can tell the difference with scopes, imaging and labs.

I think of medicines the way I think of the supplements in this guide: as tools that can help the body heal. Biologics, immunomodulators, mesalamine, a course of steroids to break a flare, these have saved bowel and saved lives, and there is no shame and no failure in needing them. Many people in remission on medication use supplements alongside them, with their team's knowledge, and that is a perfectly good place to be.

And a caution that runs the other way: **supplements and herbs are not automatically safer than prescription drugs.** "Natural" is not a safety category. Several entries in this guide interact with IBD medications (the interaction tables say so) and a few have real toxicity at high doses. Treat them with the same respect you'd give a prescription: know the dose, know the interactions, tell your team what you take.

One more thing your team will agree with me on: be very careful with NSAIDs. Ibuprofen, naproxen and aspirin at pain-relief doses damage the gut lining directly; researchers use high-dose NSAIDs to *induce* colitis in animal models, and in people they are a well-recognized flare trigger. A headache is not worth a flare. Ask your team what to reach for instead.

Bring this guide to your GI

Print the section on any supplement you're considering and bring it in. A gastroenterologist who has never heard of half these compounds can still read a study table with doses on it, and a table is much harder to dismiss than a bottle.

Who wrote this

About me, and why I wrote this

I'm **Andrew Kornfeld**. I have Crohn's disease, I have been in remission since 2014, and I have spent nine years working with people who have IBD. This guide is the thing I have been meaning to make for most of that time: the supplements and herbs I actually believe in, with the evidence and the exact products, in front of the people who need them. I never found a comprehensive source on supplements and IBD, so I built one.



Hiking in Florianópolis, Brazil

I was diagnosed in high school, and for a long time I did what most people with Crohn's do: I took the medications, I got by, and I never quite felt well. What changed things was learning to treat my body as a system, one where the medical plan, what I eat, how I move, how I sleep, how I handle stress, and yes, what supplements and herbs I take, all have interconnected effects on my Crohn's disease at the same time. Everything I take acts on the scientifically established mechanisms of IBD, and Section B is that idea drawn out. I studied neuroscience and psychology at UC Santa Cruz, spent time in medical school, and decided I could do more good outside the exam room. The modality I practice now, systems-based health coaching, grew out of that: it looks at every aspect of a person's life and helps them become a superhuman version of themselves in tackling IBD. It is non-dogmatic, and I work alongside people's medical teams, never in place of them. I am a health educator and a health coach; I am not your doctor.

These days I live and travel in South America with my family, back and forth to the United States. I am 37, and I am stronger and in the best shape of my life. Surfing, mountain biking, a hard workout and the sleep that follows do as much for my Crohn's as anything in a bottle, and you will find that conviction all over this guide. The goal I name out loud is simple: to be the kind of person who can still exercise with his great-grandchildren. I have talked with hundreds of gastroenterologists and thousands of people with IBD, and I believe deeply in following the science and in getting your team's explicit sign-off before you change anything.

I stayed out of the supplement business on purpose for years. This guide is how I have decided to make my impact: real product highlights, the financial arrangement printed once on the page headed "Please read this first," and the newest version always free at supplementsforibd.com.

Diagnosis
Crohn's disease, since high school; in remission since 2014

Training
Neuroscience and psychology, UC Santa Cruz

Work
Founder & CEO, Systema Health; systems-based health coaching

Home
South America, with regular time in the US

Loves
Exercise, the outdoors, the ocean, cooking

Takes
A lot of these; see "My personal protocol," Section N

I can help you one-on-one

If you want help putting all of this into practice, diet, mindset, medication decisions with your team, and a supplement plan built for your case, Systema works with a small number of people with IBD directly.

Apply to work with Systema

systema.health/apply-now

Peer review, ongoing

This guide is self-published, and it is still under transdisciplinary peer review by gastroenterologists, primary care physicians, integrative practitioners, dietitians, PhD scientists and other health coaches. That will take time. Always verify your own facts.

Feedback welcome. If you find a mistake or see a way we can improve, email **help@supplementsforibd.com**. We would love to hear from you.



C

SECTION C · 23 ENTRIES · 10 WITH A PRODUCT

Anti-Inflammatories

Twenty-three entries whose job is to quiet the immune signaling that damages the gut wall: the polyphenols that keep NF-κB switched off, the resins that reach the leukotriene arm curcumin does not, the antioxidants that feed the cell's own repair, and the medicinal mushrooms. Inflammation is the part of the loop the medications act on, and it is the part where supplements have the most human trial evidence, so this is the largest section in the guide and the one where the evidence bars vary most: from randomized trials in ulcerative colitis at the top to mouse models and tradition at the bottom, with the bar printed on every card so you can tell them apart. Ten entries are highlighted with a product; the mushrooms and a few others are linked in the list. Curcumin, quercetin and omega-3 would head this list; they sit in the Five instead. Boswellia (C-02) carries the only placebo-controlled trial in microscopic colitis anywhere in this guide.

IN THIS SECTION, WITH A PRODUCT

Bilberry 38 **Boswellia** 38 **Green tea / EGCG** 39 **Ginger** 39 **Resveratrol** 40 **Melatonin** 40 **NAC** 41
Glutathione (liposomal) 41 **Alpha-lipoic acid** 42 **CoQ10** 42

Browse this whole section in my Fullscript dispensary

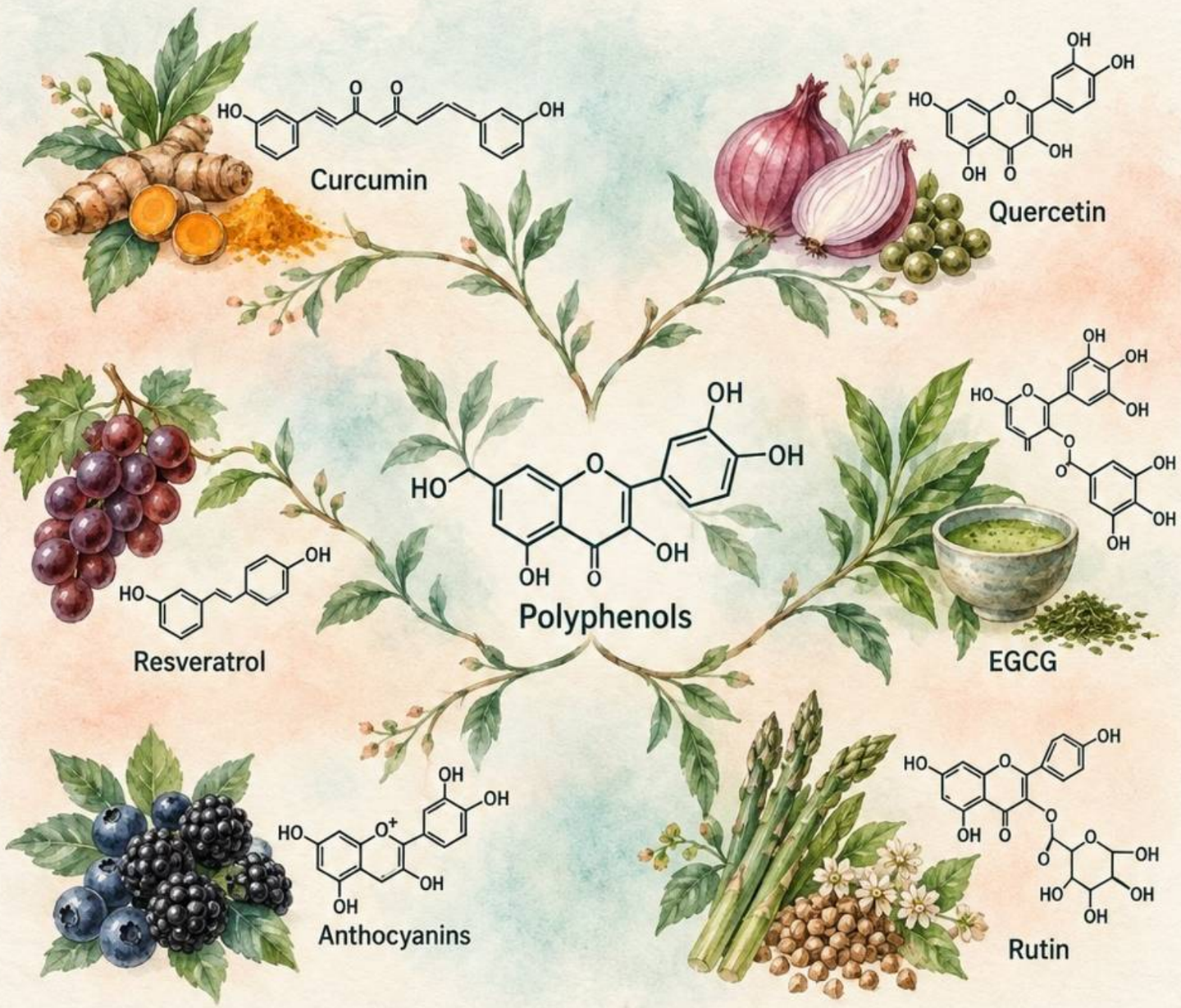
go.supplementsforibd.com/anti-inflammatories

Illustration: Frankincense resin, turmeric, green tea and bilberry

Never make changes to your protocol without consulting your gastroenterologist.

SECTION C · ANTI-INFLAMMATORIES · ONE FAMILY, DRAWN

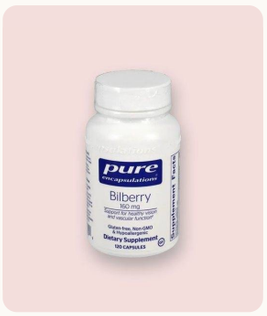
The polyphenol family



One ring at the center, six relatives around it. Much of the color on a plate is polyphenol chemistry: the gold of turmeric, the purple-blue of bilberries, the red of grape skin and onion, the green of tea. Plants make these ring-shaped molecules to handle light, stress and pests, and the same electron-donating rings quench oxidative stress in us and fit the pockets of the proteins that run inflammation, NF-κB above all. Color is a clue to chemistry, not a promise: a bright plant can be inedible and a pale one can be rich in these compounds. Curcumin comes from turmeric, quercetin from red onions and capers, resveratrol from grape skins, EGCG from green tea, anthocyanins from bilberries, rutin from buckwheat. They are poorly absorbed, and that is not entirely a flaw: a large share stays in the gut and meets the microbiome, which is where much of their work in IBD is done. Food first, then the standardized extract when food cannot reach the dose.

Never make changes to your protocol without consulting your gastroenterologist.

Section C · Anti-Inflammatories · highlighted products





Bilberries

C-01 · #6

Bilberry / anthocyanins

Pure Encapsulations, Bilberry 160 mg · 120 caps

Inflammation · Barrier · Nourish

Anthocyanins from European blueberry. In a Zurich open-label study, six weeks of an anthocyanin-rich bilberry preparation put 63% of mild-to-moderate UC patients into remission and cut fecal calprotectin by more than half; biopsies showed less TNF-alpha and IFN-gamma. A 2024 multicenter RCT of the extract in moderate-to-severe UC missed its clinical endpoint (stopped early, high placebo response) but again lowered calprotectin. Standardized to 25% anthocyanosides.

Pricey for what it is; food (frozen blueberries) covers a lot of this ground.

References 40–42

Andrew's notes

Bilberry is one of my go-to options in my work, and the most potent anthocyanin-containing fruit I know, with pomegranate close behind; pomegranate you can simply drink as juice. The open-label UC data match what I see: this is one of the polyphenols people actually notice. Frozen blueberries cover much of the same ground for far less, and I say so before I mention the capsule.

Buy on Fullscript →

go.supplementsforibd.com/bilberry

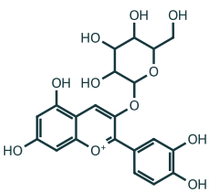
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Evidence 3

Positive open-label UC study; a 2024 RCT positive on calprotectin, not on symptoms

Andrew's score 5

Andrew's judgment, 1–5.



Cyanidin-3-glucoside, a bilberry anthocyanin · $C_{21}H_{21}O_{11}^+$ · 449.4 g/mol · PubChem CID 441667





Frankincense resin

C-02 · #7

Boswellia serrata

Thorne, Boswellia Phytosome · 60 caps

Inflammation

Frankincense resin; its boswellic acids inhibit 5-lipoxygenase, the leukotriene arm of inflammation that curcumin and omega-3 don't touch. Two 2001 trials found it comparable to mesalazine in active Crohn's and to sulfasalazine in chronic colitis; a 2011 placebo-controlled maintenance trial in Crohn's (n = 82) found no benefit but confirmed safety. In microscopic colitis it is the only supplement in this guide with a placebo-controlled trial: in collagenous colitis, 400 mg three times daily for six weeks put 64% into remission against 27% on placebo per protocol, a result that did not hold on intention-to-treat analysis (n = 31). Phytosome form for absorption, the same delivery logic as the curcumin.

Occasional reflux; separate from other fat-soluble supplements if it bothers you.

References 43–46

Andrew's notes

My own observations with boswellia are positive, though less dramatic than the trials would suggest, which is why my score stays at a 3. It seems to help most where the inflammation has the leukotriene flavor curcumin does not reach. Microscopic colitis: this is the one entry in the guide with a placebo-controlled trial in your disease, small as it was.

Buy on Fullscript →

go.supplementsforibd.com/boswellia

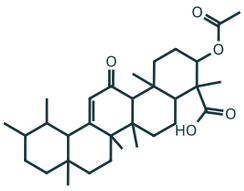
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Evidence 3

Comparator trials positive; Crohn's maintenance trial negative; one small positive trial in collagenous colitis

Andrew's score 3

Andrew's judgment, 1–5.



AKBA, the lead boswellic acid · $C_{32}H_{48}O_5$ · 512.7 g/mol · PubChem CID 11168203

Section C · Anti-Inflammatories · highlighted products, continued





Green tea / matcha

C-04 · #9

Green tea / EGCG

Pure Encapsulations, Green Tea Extract (decaffeinated) · 120 caps

Inflammation · Nourish · Modulate

EGCG, the principal catechin. In a small double-blind pilot (n = 19), 400 to 800 mg/day of purified EGCG for 56 days produced a 67% response rate versus 0% on placebo in mild-to-moderate UC refractory to mesalamine or azathioprine; a retrospective series also reported improvement in refractory pouchitis. This extract is decaffeinated and standardized to 70% EGCG.

High-dose green-tea extracts have rare liver signals, take with food, not fasting.

References 50–51

Andrew's notes

Personally I would rather drink ceremonial-grade matcha, which delivers EGCG along with the rest of the leaf and the ritual of a cup. The capsule is the right tool when you do not have access to good matcha, when you are traveling, or when you simply will not whisk a bowl every morning. The extract-specific caution stands: concentrated extracts have rare liver signals that a cup of tea does not, so take it with food.

Buy on Fullscript →

go.supplementsforibd.com/green-tea

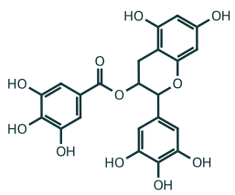
SKU PUR-GT6

Evidence 3

Pilot RCT in UC

Andrew's score 4

Andrew's judgment, 1–5.



EGCG, epigallocatechin gallate · $C_{22}H_{18}O_{11}$ · 458.4 g/mol · PubChem CID 65064





Ginger root

C-05 · #10

Ginger

Pure Encapsulations, Ginger Extract · 120 caps

Inflammation

In a 12-week randomized trial in mild-to-moderate UC, 2,000 mg/day of dried ginger lowered the oxidative-stress marker MDA and improved disease-activity scores versus placebo. Also a spasmolytic and anti-nausea agent, useful for the cramping and queasiness that ride along with active disease.

Additive antiplatelet effect with anticoagulants.

References 52–53

Andrew's notes

I would rather eat ginger or drink fresh ginger tea, which is what I do at home. The supplement earns its place when I am traveling or when fresh preparation is impractical, and this is a good product for that. Ginger is also one of the gentlest things in this section for the cramping and queasiness of active disease.

Buy on Fullscript →

go.supplementsforibd.com/ginger

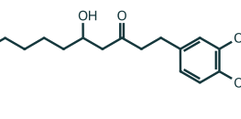
SKU PUR-GI1

Evidence 4

One positive RCT in UC

Andrew's score 4

Andrew's judgment, 1–5.



6-Gingerol · $C_{17}H_{26}O_4$ · 294.4 g/mol · PubChem CID 442793

Section C · Anti-Inflammatories · highlighted products, continued





Grapes, knotweed

C-06 · #11

Resveratrol

Pure Encapsulations, Resveratrol · 60 caps

Inflammation · Nourish

trans-Resveratrol from Japanese knotweed. A randomized UC trial found lower inflammatory markers and better quality-of-life scores over six weeks. Only 40 mg per capsule, check the label before comparing with study doses.

Interacts with several drugs through CYP3A4; ask if you take tacrolimus or cyclosporine.

References 54–57

Andrew's notes

I have noticed huge benefits with resveratrol. After the anthocyanins in bilberry, I would say it is probably the most powerful polyphenol for IBD and inflammatory conditions, and it leans on cytokines that curcumin does not. Read the label before comparing with the trials: this capsule carries 40 mg, well below the study doses.

Buy on Fullscript →

go.supplementsforibd.com/resveratrol

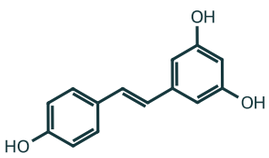
SKU PUR-RE6

Evidence 4

Two positive RCTs in UC from one group

Andrew's score 5

Andrew's judgment, 1–5.



Resveratrol · $C_{14}H_{12}O_3$ · 228.2 g/mol · PubChem CID 445154





Tart cherries, a food source

C-08 · #13

Melatonin

Klaire Labs / SFI Health, Melatonin Lozenge 1 mg (cherry, dissolve or chew) · 60 lozenges

Inflammation · Barrier

Not just a sleep hormone, the gut makes far more melatonin than the pineal gland, and it acts on the gut wall directly. A randomized UC trial found melatonin as an adjunct to mesalamine helped maintain remission. Sleep loss is itself pro-inflammatory. The product is deliberately a 1 mg lozenge you dissolve or chew; in my experience people do best on 1 mg or less, and most bottles start at 3 mg.

Label flags autoimmune disease and corticosteroid use as cautions, talk to your team. Contains mannitol and magnesium stearate; the label carries a wheat statement.

Reference 61

Andrew's notes

Use this very carefully and sparingly, at night. It's especially good for jet lag. In my opinion it is much more a drug and a hormone than a supplement, and people generally take far too much; in my experience 1 mg is often plenty, which is why the product I link is a 1 mg lozenge.

Buy on Fullscript →

go.supplementsforibd.com/melatonin

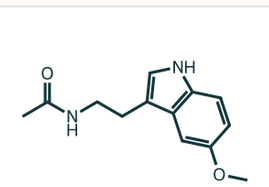
SKU KLP-ML1

Evidence 4

One positive RCT in UC

Andrew's score 2

Andrew's judgment, 1–5.



Melatonin · $C_{13}H_{16}N_2O_2$ · 232.3 g/mol · PubChem CID 896

Section C · Anti-Inflammatories · highlighted products, continued



C-10 · #15

N-acetylcysteine (NAC)

Pure Encapsulations, NAC 600 mg · 90 caps

Inflammation · Barrier

N-acetylcysteine, the rate-limiting precursor to glutathione, and a mucolytic that thins mucus. A Spanish pilot RCT (n = 37) added 800 mg/day of NAC to mesalamine for four weeks in mild-to-moderate UC: remission 63% vs 50%, not statistically significant, with a fall in the chemokines MCP-1 and IL-8 only in the NAC group.

Sulfur smell is normal. Mild nausea at higher doses.

References 62–63

Andrew's notes

I have seen some benefit personally, and NAC is not one of the first things I reach for. It is a reasonable option when the supplements and herbs with more evidence are not doing enough, particularly for people who tolerate it better than glutathione. Keep it separate from glutathione (C-11) in your thinking: NAC is the precursor, and its evidence is its own.

Buy on Fullscript →

go.supplementsforibd.com/nac

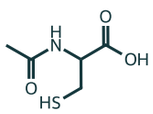
SKU PUR-NA69

Evidence 3

Small adjunct RCT in UC; primary endpoint not significant

Andrew's score 3

Andrew's judgment, 1–5.



N-acetylcysteine · $C_5H_9NO_3S$ · 163.2 g/mol · PubChem CID 12035



C-11 · #16

Glutathione (liposomal)

Quicksilver Scientific, Liposomal Glutathione, Lemon Mint · 50 mL

Inflammation

The body's master antioxidant: the tripeptide every cell makes to quench oxidative stress, detoxify, and recycle vitamins C and E, and it is measurably depleted in inflamed gut mucosa. Glutathione swallowed as a plain capsule is largely digested before it is absorbed; this liquid wraps it in sunflower-derived phospholipid liposomes and is pumped under the tongue and held there, which is the delivery logic. Each 1 mL (two pumps) carries 100 mg of reduced glutathione with 75 mg of phosphatidylcholine; label checked September 2026. A softgel alternative is listed below.

Refrigerate on arrival and use within 30 days of opening. Contains ethanol and glycerin as carriers. Sulfur smell and mild nausea happen in some people.

Andrew's notes

This is the king of antioxidants: the molecule the cell makes to quench oxidative stress and to recycle vitamins C and E, and it is measurably depleted in inflamed gut tissue. Some people have trouble with it, possibly because of the sulfur-containing component, so introduce it on its own and watch. The form I now feature is Quicksilver Scientific's liposomal liquid, pumped under the tongue, because glutathione swallowed as a plain capsule is largely digested; the softgel remains a fine alternative.

Buy on Fullscript →

go.supplementsforibd.com/glutathione-liquid

SKU QSL-Q1005

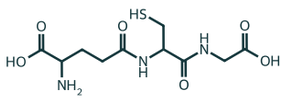
Also Pure Encapsulations Liposomal Glutathione, go.supplementsforibd.com/glutathione

Evidence 2

Mechanistic; adjacent human data

Andrew's score 3

Andrew's judgment, 1–5.



Glutathione · $C_{10}H_{17}N_3O_6S$ · 307.3 g/mol · PubChem CID 124886

Section C · Anti-Inflammatories · highlighted products, continued



C-12 · #17

Alpha-lipoic acid

Pure Encapsulations, Alpha Lipoic Acid 400 mg · 60 caps

Inflammation

A mitochondrial antioxidant that regenerates glutathione and vitamins C and E. Case-level IBD data only; deep evidence in diabetic neuropathy. Also present in the O.N.E. multivitamin.

Can lower blood sugar; caution with diabetes medication.

Andrew's notes

Alpha-lipoic acid is generally better tolerated than glutathione in my experience, and it is a great antioxidant in its own right: it regenerates glutathione and vitamins C and E and works inside the mitochondria. It is already present in the O.N.E. multivitamin at a small dose, so check before doubling up. I think of it as a supporting player rather than a lead.

Buy on Fullscript →

go.supplementsforibd.com/alpha-lipoic-acid

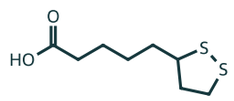
SKU PUR-AL46

Evidence 2

Adjacent RCTs; case-level IBD data

Andrew's score 3

Andrew's judgment, 1–5.



Alpha-lipoic acid · $C_8H_{14}O_2S_2$ · 206.3 g/mol · PubChem CID 6112



C-13 · #18

CoQ10

Pure Encapsulations, CoQ10 120 mg · 30 caps

Inflammation

The electron-transport cofactor. Mitochondrial dysfunction is a real feature of IBD epithelium, and CoQ10 is depleted by statins. Note: the O.N.E. multivitamin already contains CoQ10, check before doubling up.

Mild; can reduce warfarin effect.

Reference 64

Andrew's notes

Just a great nutrient, especially for the mitochondria, whose dysfunction is real in IBD. It may also help with longevity and general health.

Buy on Fullscript →

go.supplementsforibd.com/coq10

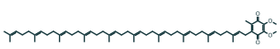
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Evidence 2

Mechanistic; adjacent data

Andrew's score 3

Andrew's judgment, 1–5.

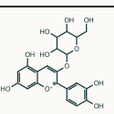
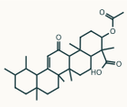
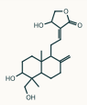
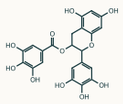
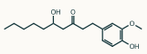
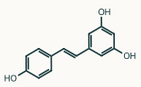
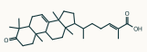
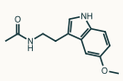
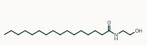
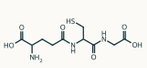
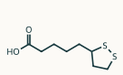


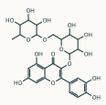
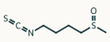
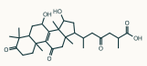
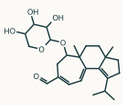
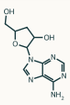
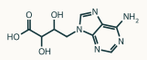
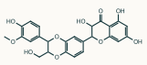
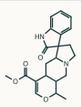
Coenzyme Q10, ubiquinone · $C_{59}H_{90}O_4$ · 863.3 g/mol · PubChem CID 5281915

Section C · Anti-Inflammatories

All 23 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
6	C-01	★ **Bilberry / anthocyanins** Inflammation		Evidence 3 Andrew 5	Pure Encapsulations Bilberry 160 mg go.supplementsforibd.com/bilberry	Open-label UC data; anthocyanin pigment of European blueberry References 40–42
7	C-02	★ **Boswellia serrata** Inflammation		Evidence 3 Andrew 3	Thorne Boswellia Phytosome go.supplementsforibd.com/boswellia	5-lipoxygenase inhibitor; older CD and UC trials, mixed References 43–46
8	C-03	**Andrographis paniculata** Inflammation		Evidence 4 Andrew —	no product —	A double-blind trial found the standardized extract HMPL-004 comparable to mesalazine in active UC; a 224-patient placebo-controlled trial then found 60% response at 1,800 mg/day versus 40% on placebo (remission not significantly different). No clean single-ingredient product on Fullscript. References 47–49
9	C-04	★ **Green tea / EGCG** Inflammation		Evidence 3 Andrew 4	Pure Encapsulations Green Tea Extract (decaffeinated) go.supplementsforibd.com/green-tea	Pilot RCT in UC; strong preclinical base References 50–51
10	C-05	★ **Ginger** Inflammation		Evidence 4 Andrew 4	Pure Encapsulations Ginger Extract go.supplementsforibd.com/ginger	Randomized UC trial on oxidative-stress markers References 52–53
11	C-06	★ **Resveratrol** Inflammation		Evidence 4 Andrew 5	Pure Encapsulations Resveratrol go.supplementsforibd.com/resveratrol	Randomized UC trial on inflammatory markers References 54–57
12	C-07	**Mastic gum** Inflammation		Evidence 3 Andrew —	Jarrow Formulas Mastic Gum 500 mg go.supplementsforibd.com/mastic-gum	Chios mastic resin: a small Greek open-label Crohn's study reported lower CRP and IL-6 over four weeks, it reduced colitis in a rat model, and a clinical trial of a mastic supplement in IBD is registered. Traditionally used for H. pylori and dyspepsia. Contains magnesium stearate. References 58–60
13	C-08	★ **Melatonin** Inflammation		Evidence 4 Andrew 2	Klaire Labs / SFI Health Melatonin Lozenge 1 mg (cherry, dissolve or chew) go.supplementsforibd.com/melatonin	Randomized UC trial as adjunct to mesalamine Reference 61
14	C-09	**Palmitoylethanolamide (PEA)** Inflammation		Evidence 2 Andrew —	no product —	Randomized data in IBS and chronic pain; calms mast cells and glia. No IBD trials and no clean single-ingredient product.
15	C-10	★ **N-acetylcysteine (NAC)** Inflammation		Evidence 3 Andrew 3	Pure Encapsulations NAC 600 mg go.supplementsforibd.com/nac	Glutathione precursor; adjunct trial in UC References 62–63
16	C-11	★ **Glutathione (liposomal)** Inflammation		Evidence 2 Andrew 3	Quicksilver Scientific Liposomal Glutathione, Lemon Mint; Pure Encapsulations Liposomal Glutathione go.supplementsforibd.com/glutathione-liquid go.supplementsforibd.com/glutathione	Master antioxidant; depleted in inflamed mucosa
17	C-12	★ **Alpha-lipoic acid** Inflammation		Evidence 2 Andrew 3	Pure Encapsulations Alpha Lipoic Acid 400 mg go.supplementsforibd.com/alpha-lipoic-acid	Mitochondrial antioxidant

18	C-13	★ **CoQ10** ● Inflammation		Evidence 2 Andrew 3	Pure Encapsulations CoQ10 120 mg go.supplementsforibd.com/coq10	Electron-transport cofactor Reference 64
19	C-14	**Rutin** ● Inflammation		Evidence 1 Andrew —	no product —	Converted to quercetin by colonic bacteria and protective in colitis models. Buckwheat and citrus are rich food sources; no product needed. Reference 65
20	C-15	**Sulforaphane** ● Inflammation		Evidence 1 Andrew —	Thorne Broccoli Seed Extract (formerly Crucera-SGS) go.supplementsforibd.com/sulforaphane	Nrf2 activator; protective in colitis models, human data in other conditions. Thorne's extract standardizes glucoraphanin, the precursor. Reference 66
21	C-16	**Reishi** ● Inflammation		Evidence 1 Andrew —	Host Defense Reishi go.supplementsforibd.com/reishi	Triterpenes and beta-glucans with immunomodulatory activity in lab and animal studies. Host Defense products are mycelium grown on rice, not fruiting-body extracts. Reference 67
22	C-17	**Turkey tail** ● Inflammation		Evidence 2 Andrew —	Host Defense Turkey Tail go.supplementsforibd.com/turkey-tail	PSK/PSP polysaccharides; a small human study found turkey tail increased Bifidobacterium and Lactobacillus. Mycelium-on-rice product.
23	C-18	**Lion's mane** ● Inflammation		Evidence 3 Andrew —	Host Defense Lion's Mane go.supplementsforibd.com/lions-mane	Erinacines and hericenones; improvement in a mouse UC model. A 2024 Italian retrospective study found a lion's-mane-based multi-compound add-on (with berberine, quercetin, niacin and biotin) improved response to mesalazine in mild-to-moderate UC. Mycelium-on-rice product. Reference 68
24	C-19	**Cordyceps** ● Inflammation		Evidence 1 Andrew —	Host Defense Cordyceps go.supplementsforibd.com/cordyceps	Cordycepin; anti-inflammatory in animal models. Mycelium-on-rice product.
25	C-20	**Maitake** ● Inflammation		Evidence 1 Andrew —	Host Defense Maitake go.supplementsforibd.com/maitake	D-fraction beta-glucan; immunomodulatory in animal models. Includes fruiting body.
26	C-21	**Shiitake** ● Inflammation		Evidence 1 Andrew —	no product —	Lentinan; preclinical only. No standalone product; eat the mushroom.
27	C-22	**Milk thistle** ● Inflammation		Evidence 4 Andrew —	Pure Encapsulations Silymarin go.supplementsforibd.com/milk-thistle	An Iranian double-blind trial (n = 80, UC in remission) found 140 mg/day of silymarin for six months raised hemoglobin, lowered ESR, and kept 35 of 38 in remission versus 21 of 32 on placebo. Also protects the liver in people taking methotrexate. Reference 69
28	C-23	**Cat's claw** ● Inflammation		Evidence 1 Andrew —	no product —	Traditional anti-inflammatory; NF-kB inhibition in the lab; no IBD trials and no clean product.



D

SECTION D · 15 ENTRIES · 4 WITH A PRODUCT

Microbiome Nourishing

Fifteen entries that feed or restore the organisms that keep the gut calm. My view, after a decade of watching: probiotics are often overhyped in IBD, and most of the trials disappoint, but the right organism for the right person can be important, which is why four organisms are highlighted here alongside the fibers that feed them. As a broad rule, probiotics are better tolerated and more effective in ulcerative colitis than in Crohn's, though people with either can benefit from them and be bothered by them. Whatever you introduce, introduce it gradually and let tolerance set the pace; that applies to the fibers as much as to the organisms. One entry, spore-based probiotics, is here so you know why I *don't* recommend it. If your diagnosis is microscopic colitis, note that the AGA guideline suggests against probiotics for inducing remission; in my own work I have seen selected organisms help some people with MC, and I hold that observation next to the guideline rather than against it.

IN THIS SECTION, WITH A PRODUCT

Akkermansia muciniphila 46 **S. boulardii** 46 **Multi-strain L+B** 47 **L. plantarum 299v** 47

Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/microbiome-nourishing

Illustration: Soluble fiber and the organisms it feeds

Never make changes to your protocol without consulting your gastroenterologist.

Section D · Microbiome Nourishing · highlighted products



D-01 · #29

Akkermansia muciniphila

Pendulum, Akkermansia · 30 caps

Nourish · Barrier

The mucin-layer resident most consistently depleted in IBD, now available as a single-strain product for the first time. No IBD intervention trials yet, this is a mechanism bet, and I'm making it. Refrigerate.

Start slowly; some people bloat in week one.

References 70–73

Andrew's notes

I have seen this probiotic do extremely powerful things for selected people, and I have moved my score from a 5 to a 4 to keep it honest: the evidence is preclinical and observational, and my observations are exactly that, observations. Akkermansia is the organism most consistently depleted in IBD, which is why I make the mechanism bet. Start slowly; a few people bloat in the first week.

Buy on Fullscript →

go.supplementsforibd.com/akkermansia

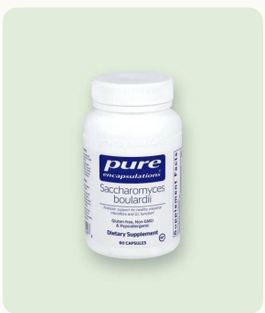
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Evidence 1

Preclinical + observational depletion data

Andrew's score 4

Andrew's judgment, 1–5.





Lychee, where S. boulardii was first isolated

D-02 · #30

Saccharomyces boulardii

Pure Encapsulations, Saccharomyces Boulardii · 60 caps

Nourish · Inflammation · Barrier

A probiotic yeast, not a bacterium, so antibiotics don't kill it. A small Italian trial (n = 32) found relapse in 6% of Crohn's patients on mesalamine plus S. boulardii versus 38% on mesalamine alone; a much larger French trial (n = 165) then found no difference in relapse over a year, with a possible benefit only in non-smokers. Mixed, but the deepest trial record of any single organism here. Also useful alongside antibiotics.

Not for anyone with a central line or severe immunosuppression, rare fungemia reports.

References 74–75

Andrew's notes

Start low. S. boulardii is a yeast, so antibiotics do not kill it, which makes it the organism I reach for alongside an antibiotic course. The trial record in Crohn's is mixed and the card says so; the caution about central lines and severe immunosuppression is real and not one to skip.

Buy on Fullscript →

go.supplementsforibd.com/saccharomyces-boulardii

SKU PUR-SB6

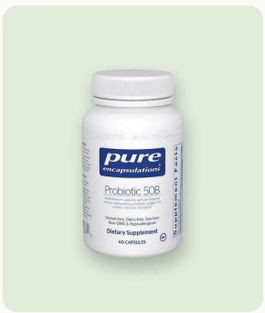
Evidence 3

Mixed RCTs in Crohn's

Andrew's score 4

Andrew's judgment, 1–5.

Section D · Microbiome Nourishing · highlighted products, continued





Fermented foods

D-04 · #32

Multi-strain Lactobacillus / Bifidobacterium

Pure Encapsulations, Probiotic 50B · 60 caps

Nourish · Inflammation

The one multi-strain product I'll put my name on: seven Lactobacillus and Bifidobacterium strains, 50 billion CFU, dairy- and soy-free. I'm not a big believer in probiotics for IBD generally (most trials disappoint) but if you're going to take one, this is the profile.

Refrigerate. Immunosuppressed readers should ask their team first.

References 76–77

Andrew's notes

Start slow, and I mean it: a fraction of the dose for the first week if the manufacturer's instructions and the capsule design allow it, then build. Probiotics are often overhyped in IBD, but the right one for the right person can still be important, and this is the one multi-strain product I trust enough to put my name on. Pro tip: you can use most of these strains to culture your own SCD-style yogurt, which is a gentler way to introduce them for some people.

Buy on Fullscript →

go.supplementsforibd.com/probiotic-50b

SKU PUR-PR506

Evidence 3

Synbiotic and multi-strain UC data

Andrew's score 3

Andrew's judgment, 1–5.



D-06 · #34

Lactobacillus plantarum 299v

Jarrow Formulas, Ideal Bowel Support 299v · 30 caps

Nourish · Barrier

Lactobacillus plantarum 299v is one of the best-characterized single probiotic strains: human-origin, acid- and bile-tolerant, and studied in randomized IBS trials for bloating and pain, with laboratory work showing it strengthens the tight-junction proteins of the intestinal lining. There is no IBD trial. It is here as the fourth organism worth knowing about because the barrier mechanism fits this guide and the tolerability record is long; it is not a rescue, and it is the least evidenced of the four in IBD specifically. Ten billion viable cells per capsule, room-temperature stable; label checked September 2026.

Contains magnesium stearate and potato starch. As with any live organism, immunosuppressed readers should ask their team first.

Reference 79

Andrew's notes

A solid, well-characterized single strain, and the one I reach for when someone wants a probiotic they can tolerate easily: bloating and gas settle for many people, and the barrier mechanism fits the story this guide tells. I have not watched it change the course of anyone's disease, which is why it sits at a 3 rather than higher. Start with one capsule and give it a month.

Buy on Fullscript →

go.supplementsforibd.com/l-plantarum

SKU JAR-IBS

Evidence 2

Randomized IBS trials; tight-junction studies; no IBD trial

Andrew's score 3

Andrew's judgment, 1–5.

Section D · Microbiome Nourishing · a compact module

Rebuilding after a course of antibiotics

Antibiotics are sometimes unavoidable in IBD, and the weeks after a course are when people most often ask me what to take. My answer is a way of thinking, not a schedule.



A course of antibiotics thins the microbiome broadly, and the residents that keep the gut calm are among the casualties. What I suggest to the people I work with is a progression built around what their gut tolerates rather than around the calendar. First, small amounts of the soft, well-cooked foods they already know they handle, with blended and prebiotic foods introduced in small portions: cooked squash and carrot, ripe banana, a little cooked oat, a broth with vegetables cooked down. Then, as tolerance allows, a careful widening of fiber and, for those who do well with them, fermented foods. Then, and only then, a probiotic chosen for that person rather than a shelf of them.

None of this is a universal timing or order. There is no trial showing that a fixed sequence of foods and then organisms rebuilds a microbiome after antibiotics in IBD, and the guidelines do not tell you when a probiotic should start relative to a course; some organisms, notably the yeast *S. boulardii* (D-02), are taken alongside antibiotics because the antibiotic does not kill them, while bacterial products are usually started after. Your gastroenterologist or dietitian should shape the timing to your disease and to the antibiotic you were given.

The four organisms highlighted in this section are the ones I would consider, one at a time, and not all together: **Akkermansia** (D-01), **S. boulardii** (D-02), the **multi-strain blend** (D-04), and **L. plantarum 299v** (D-06). Nothing about listing them together says they are safe or necessary in combination, and none of them is meant for indefinite use; a probiotic is a bridge back to a diet with real plant diversity, which does more for the microbiome over a year than any bottle. Start slow, one change every couple of weeks, and stop anything that makes you feel worse.

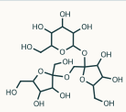
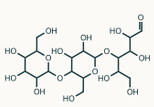
Organism	Why it might be considered	Link
Akkermansia · D-01	The mucus-layer resident most consistently depleted in IBD; a mechanism bet, taken slowly.	go.supplementsforibd.com/akkermansia
S. boulardii · D-02	A yeast, so it can be taken alongside an antibiotic course; mixed Crohn's trials.	go.supplementsforibd.com/saccharomyces-boulardii
Multi-strain blend · D-04	Seven Lactobacillus and Bifidobacterium strains; the one blend I trust.	go.supplementsforibd.com/probiotic-50b
L. plantarum 299v · D-06	A well-characterized strain with barrier data; the least evidenced of the four in IBD.	go.supplementsforibd.com/l-plantarum

Considerations to individualize with your care team, not a prescribed sequence. Immunosuppressed readers and anyone with a central line should ask before taking any live organism.

Section D · Microbiome Nourishing

All 15 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
29	D-01	★ **Akkermansia muciniphila** ● Nourish		Evidence ■□□□□ 1 Andrew ■■■■□ 4	Pendulum Akkermansia go.supplementsforibd.com/akkermansia	Mucin-layer resident depleted in IBD References 70–73
30	D-02	★ **Saccharomyces boulardii** ● Nourish		Evidence ■■■□□ 3 Andrew ■■■■□ 4	Pure Encapsulations Saccharomyces Boulardii go.supplementsforibd.com/saccharomyces-boulardii	Probiotic yeast; Crohn's maintenance trials, mixed References 74–75
31	D-03	**Spore-based probiotics** ● Nourish		Evidence ■■□□□ 2 Andrew —	no product —	**Not recommended** (Andrew's position). Spore-forming Bacillus strains with IBS data. Spores germinate unpredictably and Andrew has seen flares follow them. No product, on purpose.
32	D-04	★ **Multi-strain Lactobacillus / Bifidobacterium** ● Nourish		Evidence ■■■□□ 3 Andrew ■■■□□ 3	Pure Encapsulations Probiotic 50B go.supplementsforibd.com/probiotic-50b	Synbiotic UC trial data; B. infantis IBS data References 76–77
33	D-05	**Lactobacillus reuteri** ● Nourish		Evidence ■■■■□ 4 Andrew —	no product —	In an Italian RCT (n = 40), eight weeks of L. reuteri ATCC 55730 enemas added to mesalazine cut children's Mayo scores from 8.6 to 3.2 (placebo unchanged), with mucosal IL-10 up and TNF-alpha down. An enema, not a capsule; no clean oral single-strain product on Fullscript. Reference 78
34	D-06	★ **Lactobacillus plantarum 299v** ● Nourish		Evidence ■■□□□ 2 Andrew ■■■□□ 3	Jarrow Formulas Ideal Bowel Support 299v go.supplementsforibd.com/l-plantarum	Strain 299v has randomized IBS data and tight-junction studies. Contains magnesium stearate. Reference 79
35	D-07	**Psyllium** ● Nourish		Evidence ■■■■□ 4 Andrew —	Organic India Whole Husk Psyllium go.supplementsforibd.com/psyllium	A Spanish multicenter RCT (GETECCU, 1999) found Plantago ovata seed as effective as mesalamine for maintaining UC remission, and the combination best. Start small; bulk can bother active disease. References 80–81
36	D-08	**Partially hydrolyzed guar gum** ● Nourish		Evidence ■■□□□ 2 Andrew —	Tomorrow's Nutrition SunFiber (PHGG) go.supplementsforibd.com/phgg	Partially hydrolyzed guar gum: a low-gas soluble fiber with randomized IBS data and good short-chain-fatty-acid production. Reference 82
37	D-09	**Inulin / FOS** ● Nourish		Evidence ■■■□□ 3 Andrew —	NOW Foods Organic Inulin Powder go.supplementsforibd.com/inulin	Oligofructose-enriched inulin (Synergy 1) lowered fecal calprotectin over four weeks in an acute-UC pilot and was well tolerated; a 2023 Cochrane review finds the prebiotic evidence in UC still thin. Gas is the limiting side effect; start low. References 83–84
38	D-10	**Galacto-oligosaccharides (GOS)** ● Nourish		Evidence ■■□□□ 2 Andrew —	Klaire Labs Galactomune (GOS + β-glucan) go.supplementsforibd.com/gos	Galacto-oligosaccharides are strongly bifidogenic with randomized IBS data. This product pairs GOS with beta-glucan (D-15). Contains milk and fish. Reference 85

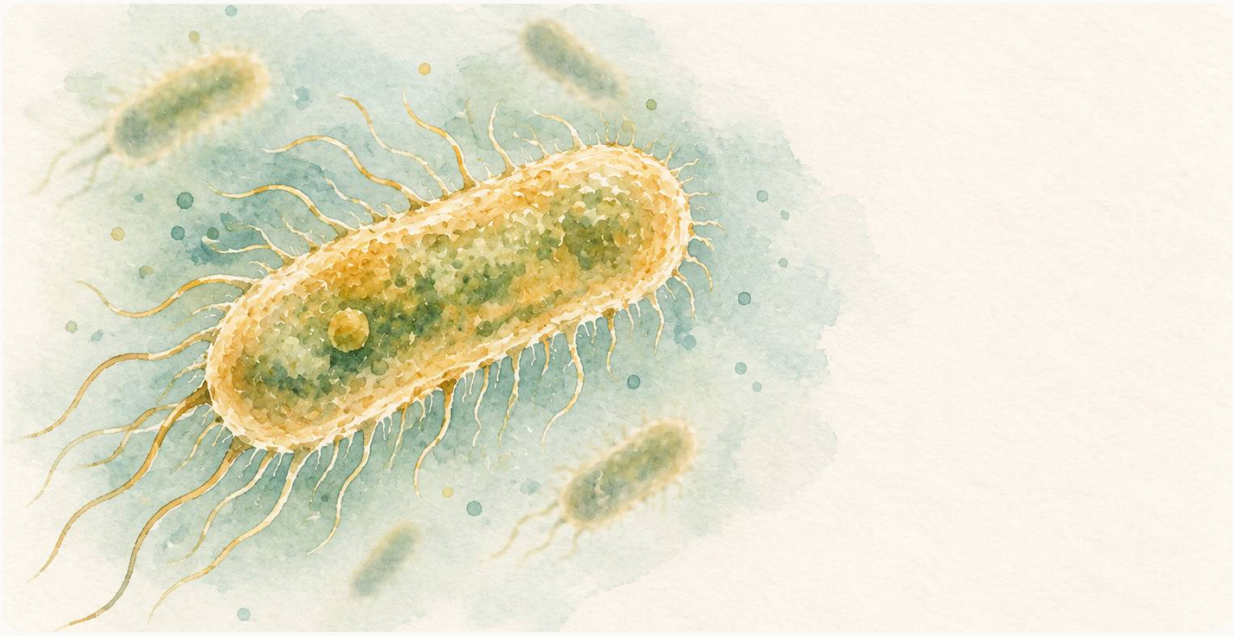
39	D-11	**Resistant starch** ● Nourish	Evidence ■■□□□ 2 Andrew –	no product —	A food, not a supplement: cooked-and-cooled potatoes, rice, green bananas. The most direct way to feed butyrate producers. Reference 86
40	D-12	**Larch arabinogalactan** ● Nourish	Evidence ■■□□□ 2 Andrew –	no product —	Larch arabinogalactan is a prebiotic with immune-modulating data in adjacent conditions. No product matched.
41	D-13	**Acacia gum** ● Nourish	Evidence ■■□□□ 2 Andrew –	no product —	Acacia is among the best-tolerated soluble fibers, with randomized IBS data. No clean single-ingredient product on Fullscript. Reference 87
42	D-14	**Lactoferrin** ● Nourish	Evidence ■■□□□ 2 Andrew –	Jarrow Formulas Lactoferrin 250 mg go.supplementsforibd.com/lactoferrin	Iron-binding whey protein with antimicrobial and immunomodulatory activity; human data in other conditions. Contains milk.
43	D-15	**Beta-glucan** ● Nourish	Evidence ■■□□□ 2 Andrew –	no product —	Yeast and oat beta-glucans train innate immunity and feed the microbiome; adjacent human data. Covered inside the Galactomune product.

Why there is no spore-based probiotic here

Spore-forming *Bacillus* probiotics are popular and heavily marketed. In my judgment they are the wrong tool for an inflamed gut, spores germinate unpredictably, and I have seen too many flares follow them. Entry D-03 stays in the list so the question is answered; it carries no product on purpose.

DEPARTMENT · ONE ORGANISM

The most missing bacterium



Faecalibacterium prausnitzii is the organism most consistently depleted in Crohn's disease, and one of the most anti-inflammatory bacteria known. In a healthy colon it can make up five to fifteen percent of everything living there. In active Crohn's it is often nearly gone, and when people who have had surgery lose it, their disease comes back sooner.

It earns its reputation three ways. It ferments fiber into **butyrate**, the colonocyte's preferred fuel and the signal that tells the goblet cell to make more mucus (F-02). It secretes a protein, MAM, that quiets NF-κB inside the epithelium. And it shifts the balance of immune messengers toward IL-10, the cytokine that tells the wall to stand down.

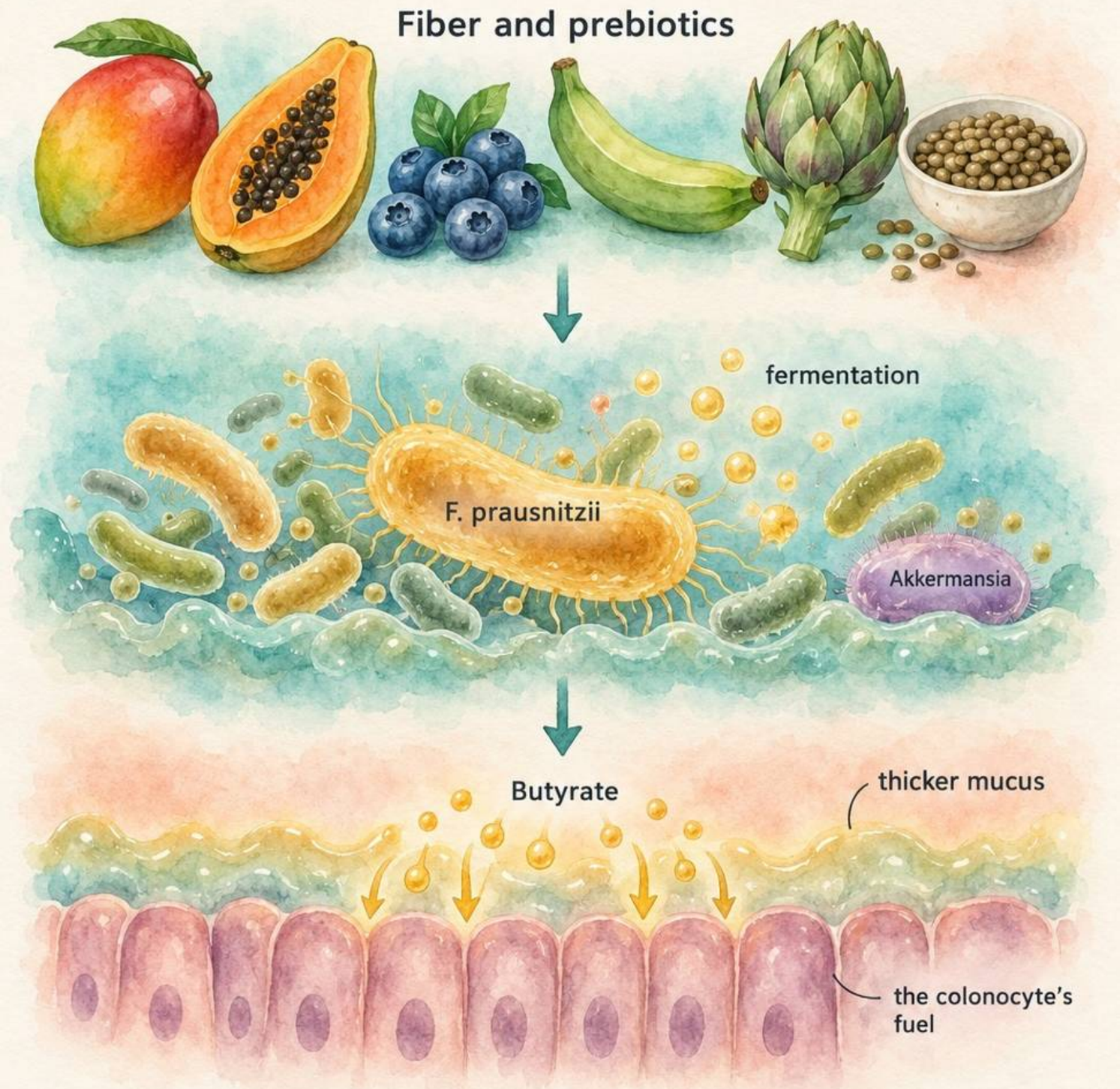
Why there is no single-strain product yet, and what is in the pipeline. It is a strict anaerobe: oxygen kills it within minutes, which is why it took decades to culture and why no capsule of it existed until very recently. Two kinds of product now exist, and they should not be confused. Multi-organism supplements that combine *F. prausnitzii* with *Roseburia* and *Akkermansia* are sold on the dispensary; they publish no survival data I can check and have no intervention trials in IBD, which is why none is linked here. Separately, single-strain *F. prausnitzii* is being developed as a drug: the French company Exeliom Biosciences published the first human trial of its strain EXL01 in April 2026, an open-label study in eight adults with mild-to-moderate Crohn's disease after steroid-induced remission, in which oral capsules were well tolerated with no treatment-related adverse events, six people completed the study and two stopped because of a flare. That is a safety and feasibility result, not proof of benefit, and it is the first time anyone has swallowed this organism inside a trial. (refs 205–206)

So the honest move is still indirect. You feed the residents you already have. Psyllium (D-07), inulin (D-09), partially hydrolyzed guar gum (D-08) and resistant starch (D-11) are the fibers it and its neighbors ferment; polyphenols such as the anthocyanins in bilberry (C-01) selectively favor it in feeding studies; and a diet with real plant diversity does more for it than any single bottle. It is the most likely first promotion into the main list in a future edition, once a product shows me it survives the bottle and a trial shows it does something.

Andrew's notes. This is the bacterium I am most excited about, and the one I think about most. I cannot yet link you to it, and I would not trust a product that claimed to deliver it without published survival data. If you are a researcher or a company working on it, I would like to hear from you: help@supplementsforibd.com. In the meantime, feed it: fiber you tolerate, color on the plate, and patience.

Illustration: a single F. prausnitzii, painted. The organism is about two micrometers long.

Fiber, fermentation and butyrate



Fiber you cannot digest is food for organisms that can. Mango, papaya, blueberries, green banana, artichoke and lentils carry pectins, resistant starch and oligosaccharides past the small intestine to the colon, where Faecalibacterium prausnitzii and its neighbors ferment them. The main product is butyrate, and butyrate is how fiber reaches the barrier: colonocytes burn it for fuel, and in laboratory studies it tightens the junctions between them and thickens the mucus above them, the link between this section and Section F. This is why Section D feeds before it kills, and why a colon starved of fiber is a colon starved of its own repair. In a flare, tolerance decides the fiber. In remission, diversity on the plate does more than any single bottle.

Never make changes to your protocol without consulting your gastroenterologist.



E

SECTION E · 7 ENTRIES · 3 WITH A PRODUCT

Microbiome Modulating

Seven antimicrobial botanicals, and a word of caution before any of them. Modulating means thinning what has overgrown, and it is the one category in this guide that can do harm to the organisms you want to keep, so it comes after the anti-inflammatories and after nourishing the microbiome, never instead of them. **In my experience the most effective and gentlest way to modulate the microbiome is dietary**: reducing the complex carbohydrates and starches that feed an overgrowth, through the **Specific Carbohydrate Diet (SCD)** or another structured approach, with a dietitian or practitioner who knows IBD. That is my view from practice, not a settled ranking from head-to-head trials. There are times when inflammation is under control and nourishment is in place and something still points at overgrowth; that is when a modulating course becomes worth considering, in a short course, with an integrative practitioner or gastroenterologist watching. A medication that is not working is a reason to talk to your gastroenterologist, not a reason to start an antimicrobial on your own. Three highlighted.

IN THIS SECTION, WITH A PRODUCT

Berberine 55 Oregano oil 55 Wormwood 56

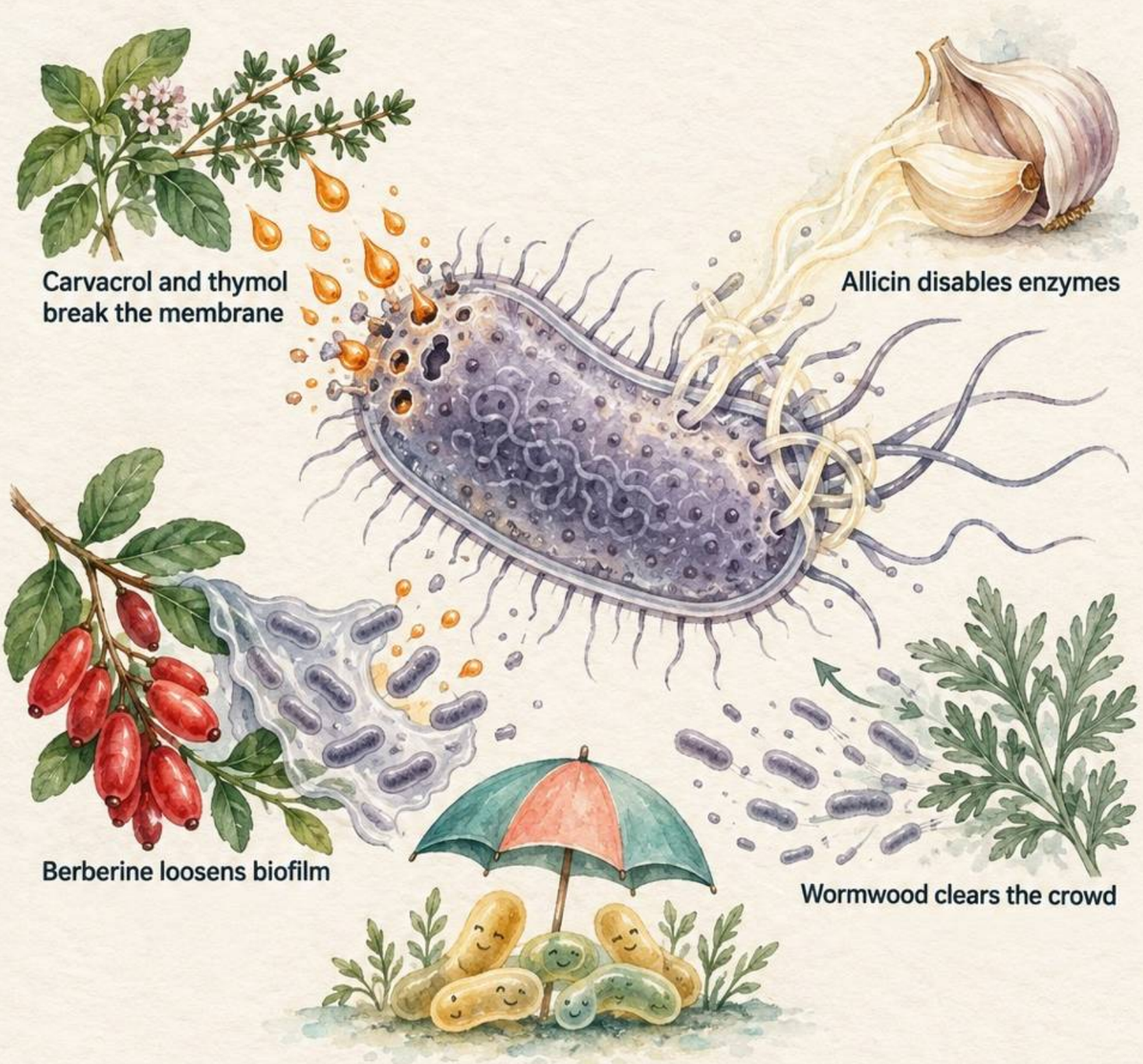
Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/microbiome-modulating

Illustration: Wormwood, barberry and oregano

Never make changes to your protocol without consulting your gastroenterologist.

Mechanisms of the antimicrobial herbs



Four ways a plant thins an overgrowth, drawn on one bacterium. Carvacrol and thymol, the oils of oregano and thyme, dissolve into the bacterial membrane and open holes in it. Allicin, released when garlic is crushed, disables enzymes a bacterium needs to run its metabolism. Berberine loosens the biofilm that shelters a colony. Wormwood is the exception: its bitters are antimicrobial in the laboratory, but in the two Crohn's trials the benefit looked immunological, with serum TNF-α falling, so "thinning the crowd" is a proposed mechanism rather than the one the trials measured. The umbrella at the bottom is the warning, not a promise: none of these mechanisms can tell a good organism from a bad one, and nothing shows that any of them shelters the residents you want to keep. Section E is a short course, after the anti-inflammatories and the nourishing fibers, never instead of them.

Never make changes to your protocol without consulting your gastroenterologist.

Section E · Microbiome Modulating · highlighted products





Barberry, goldenseal

E-01 · #44

Berberine

Thorne, Berberine · 60 caps

Modulate · Inflammation

The one antimicrobial botanical with real IBD evidence, and more of it than I expected: a 2024 meta-analysis pooled ten randomized trials (952 patients, mostly from China) of berberine added to mesalazine in UC and found higher response rates and lower endoscopic and activity scores. It also lowers blood sugar and shifts the microbiome toward short-chain-fatty-acid producers, and a US trial is testing it for colon-cancer prevention in UC.

Avoid in pregnancy; check with your team if you take tacrolimus or cyclosporine.

References 88–89

Andrew's notes

To me berberine is much more a microbiome-modulating supplement than an anti-inflammatory one, and I read its UC trials with respect and with caution: ten randomized trials pooled, mostly from China, with quality that varies. I consider a modulating approach only when the anti-inflammatories and the nourishing steps have had a fair chance and something still points at overgrowth, and I do it with an integrative practitioner or gastroenterologist watching. See the note at the top of this section on when modulating is the right move.

Buy on Fullscript →

go.supplementsforibd.com/berberine

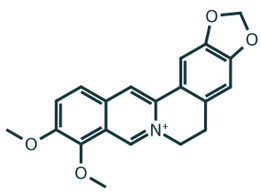
SKU THO-SF800

Evidence 5

Ten adjunct RCTs in UC, pooled; trial quality varies

Andrew's score 2

Andrew's judgment, 1–5.



Berberine · $C_{20}H_{18}NO_4^+$ · 336.4 g/mol · PubChem CID 2353





Oregano

E-02 · #45

Oregano oil

Biotics Research, A.D.P. (emulsified oregano) · 60 tabs

Modulate

Emulsified, sustained-release oregano oil, the form matters because raw oregano oil is harsh on the stomach. No IBD trials; this is here for the SIBO overlap that so many people with IBD live with.

Short courses, not forever; antimicrobials affect the good flora too.

Reference 90

Andrew's notes

Oregano oil is a very powerful antimicrobial herb, and I would not use it without an integrative practitioner's guidance. Anti-inflammatories and nourishing the microbiome should be explored thoroughly first. Short courses only; it does not distinguish the organisms you want to keep from the ones you want to thin.

Buy on Fullscript →

go.supplementsforibd.com/oregano-oil

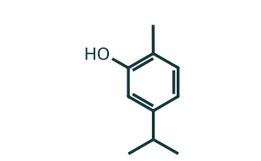
SKU BRC-1101

Evidence 1

No IBD trials; SIBO rationale

Andrew's score 2

Andrew's judgment, 1–5.



Carvacrol, the lead phenol of oregano oil · $C_{10}H_{14}O$ · 150.2 g/mol · PubChem CID 10364

Section E · Microbiome Modulating · highlighted products, continued





Sweet wormwood plant

E-04 · #47

Wormwood (Artemisia)

Gaia Herbs Pro, Sweet Wormwood (Artemisia annua), organic liquid extract · 59 mL

Modulate · Inflammation

In a 10-week double-blind trial (n = 40), Crohn's patients tapering steroids stayed in remission on a wormwood blend (65%) while most placebo patients relapsed; a second controlled trial (n = 20) found serum TNF-alpha fell from 24.5 to 8.0 pg/mL over six weeks with remission in 8 of 10 patients versus 2 of 10 controls, and mood improved. The effect looks immunological, not antimicrobial. Those trials used *Artemisia absinthium*. The product here is its close relative *Artemisia annua*, sweet wormwood (Qing Hao in Chinese medicine), the species I now use and point people to: a USDA-organic liquid extract, 0.8 mL of aerial-parts extract per 25 drops, with organic alcohol and water as the only other ingredients. Read the trial numbers as evidence for the genus, not for this exact bottle.

Not for pregnancy or lactation, and not for long-term use without supervision. Contains alcohol. Artemisia species are in the daisy family; ragweed-allergic readers should be cautious.

References 91–93

Andrew's notes

Wormwood and bitters in general have been part of my own routine for digestion, particularly after a meal, and I consider them important for that reason. That is a subjective digestive experience, and I keep it separate from the Crohn's trials, which tested a specific preparation over weeks against a disease-modifying endpoint. I am still forming my views on wormwood for IBD itself; the evidence looks promising, and I think it is worth a careful try with your team, never in pregnancy and never long-term.

Buy on Fullscript →

go.supplementsforibd.com/wormwood

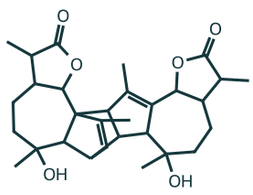
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Evidence 4

Two positive RCTs in Crohn's (A. absinthium)

Andrew's score 3

Andrew's judgment, 1–5.

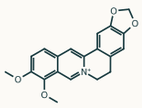
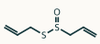
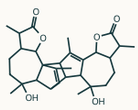
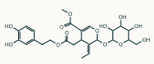
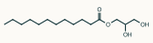


Absinthin, the bitter principle of wormwood · $C_{30}H_{40}O_6$ · 496.6 g/mol · PubChem CID 442138

Section E · Microbiome Modulating

All 7 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
44	E-01	★ **Berberine** ● Modulate		Evidence ■■■■■ 5 Andrew ■■□□□ 2	Thorne Berberine go.supplementsforibd.com/berberine	Randomized UC trial as adjunct; the only real IBD evidence here References 88–89
45	E-02	★ **Oregano oil** ● Modulate		Evidence ■□□□□ 1 Andrew ■■□□□ 2	Biotics Research A.D.P. (emulsified oregano) go.supplementsforibd.com/oregano-oil	Carvacrol/thymol; SIBO overlap Reference 90
46	E-03	**Garlic / allicin** ● Modulate		Evidence ■□□□□ 1 Andrew —	no product —	Allicin is a broad antimicrobial in the lab; no IBD trials. Cook with it instead.
47	E-04	★ **Wormwood (Artemisia)** ● Modulate		Evidence ■■■■□ 4 Andrew ■■■□□ 3	Gaia Herbs Pro Sweet Wormwood (Artemisia annua), organic liquid extract go.supplementsforibd.com/wormwood	Two steroid-sparing RCTs in Crohn's References 91–93
48	E-05	**Thyme oil** ● Modulate		Evidence ■□□□□ 1 Andrew —	no product —	Thymol is antimicrobial in the lab; no IBD trials and no product.
49	E-06	**Olive leaf extract** ● Modulate		Evidence ■□□□□ 1 Andrew —	no product —	Oleuropein; antimicrobial and antioxidant in the lab; no IBD trials.
50	E-07	**Caprylic acid / monolaurin** ● Modulate		Evidence ■□□□□ 1 Andrew —	no product —	Medium-chain fatty acids with antifungal activity in the lab; no IBD trials.

DEPARTMENT · A SHORT HISTORY

Before the capsule, the apothecary



People were using these plants long before anyone had named the diseases we now test them against. Turmeric has been part of Ayurvedic medicine in India for thousands of years, where the root was used for wounds, digestion and the skin; curcumin, the compound in Section A, is what modern chemistry later isolated from it. Berberine-bearing plants (barberry, goldenseal, Chinese goldthread) were written into the Ayurvedic and Chinese pharmacopoeias, separately, for diarrhea and dysentery two thousand years before anyone isolated the alkaloid. Wormwood gave its name to *vermouth* and to the medieval European bitters that opened the appetite before a meal; its bitter principle, absinthin, is still the reference bitter for the tongue. These are distinct traditions, and this page does not merge them.

Oregano and thyme oils were the disinfectants of the ancient Mediterranean, and carvacrol and thymol are why: both punch holes in bacterial membranes, which is exactly the property that makes them useful and dangerous in a gut that is trying to keep its good residents. Garlic sat in the Egyptian Ebers papyrus; allicin, its active molecule, exists only for minutes after a clove is crushed.

The lesson the history teaches. Traditional use tells you a plant was tolerated and did something noticeable. It does not tell you the dose, the form, or whether the something was good for an inflamed colon. Every entry in this section carries an evidence bar for that reason, and most of them sit low. That is not a dismissal; it is a to-do list for researchers.



A living tradition, close to home. Herbal medicine is not only history. In Paraguay, where I live part of the year, it is a daily social ritual: tereré, yerba mate drunk cold through a metal bombilla from a shared guampa, is prepared with *yuyos*, fresh medicinal herbs crushed into the iced water by the yuyeras who sell them at every market. UNESCO added the practice to its list of intangible cultural heritage in 2020. Different herbs for different complaints: cedrón and menta'i for the stomach, burrito and boldo for digestion, and a long list of plants people reach for by name. It is folk knowledge, largely untested by trial, and it is also the most normal thing in the world there to treat the gut with a plant. I find that humbling in both directions.

What has changed in a century is standardization: the ability to say how much berberine or carvacrol is in the bottle, and to run the trial. Berberine (E-01) now has a randomized trial in ulcerative colitis, and wormwood (E-04) has two in Crohn's, both steroid-sparing designs. The apothecary is becoming a pharmacy. Read the Section E cautions with that history in mind: these are the strongest herbs in the guide, and they were never gentle.



F

SECTION F · 13 ENTRIES · 8 WITH A PRODUCT

Barrier Repair

Thirteen entries that rebuild the wall itself: the mucus layer above it, the tight junctions that seal it, and the energy supply of the cells that make it. It opens with the fuel trio (glutamine, butyrate, creatine), because a cell repairing itself under inflammatory stress has a higher energy budget than a resting one and starving it is a strange way to ask it to heal. Then the demulcents that coat and soothe (aloe, slippery elm, marshmallow), the amino sugars that feed the mucus, and the membrane lipids that the lining is literally built from. Barrier repair is where the mechanisms of Section B stop being abstract: a leaky wall lets bacterial material cross into the immune tissue beneath, the immune tissue answers with inflammation, and inflammation loosens the wall further. Close the wall and the loop slows. Eight entries carry a product; the rest are in the list with structures and notes.

IN THIS SECTION, WITH A PRODUCT

L-glutamine 61 Butyrate 61 Creatine 62 Aloe vera (inner leaf) 62 N-acetylglucosamine 63
Phosphatidylcholine 63 Collagen peptides 64 Slippery elm 64

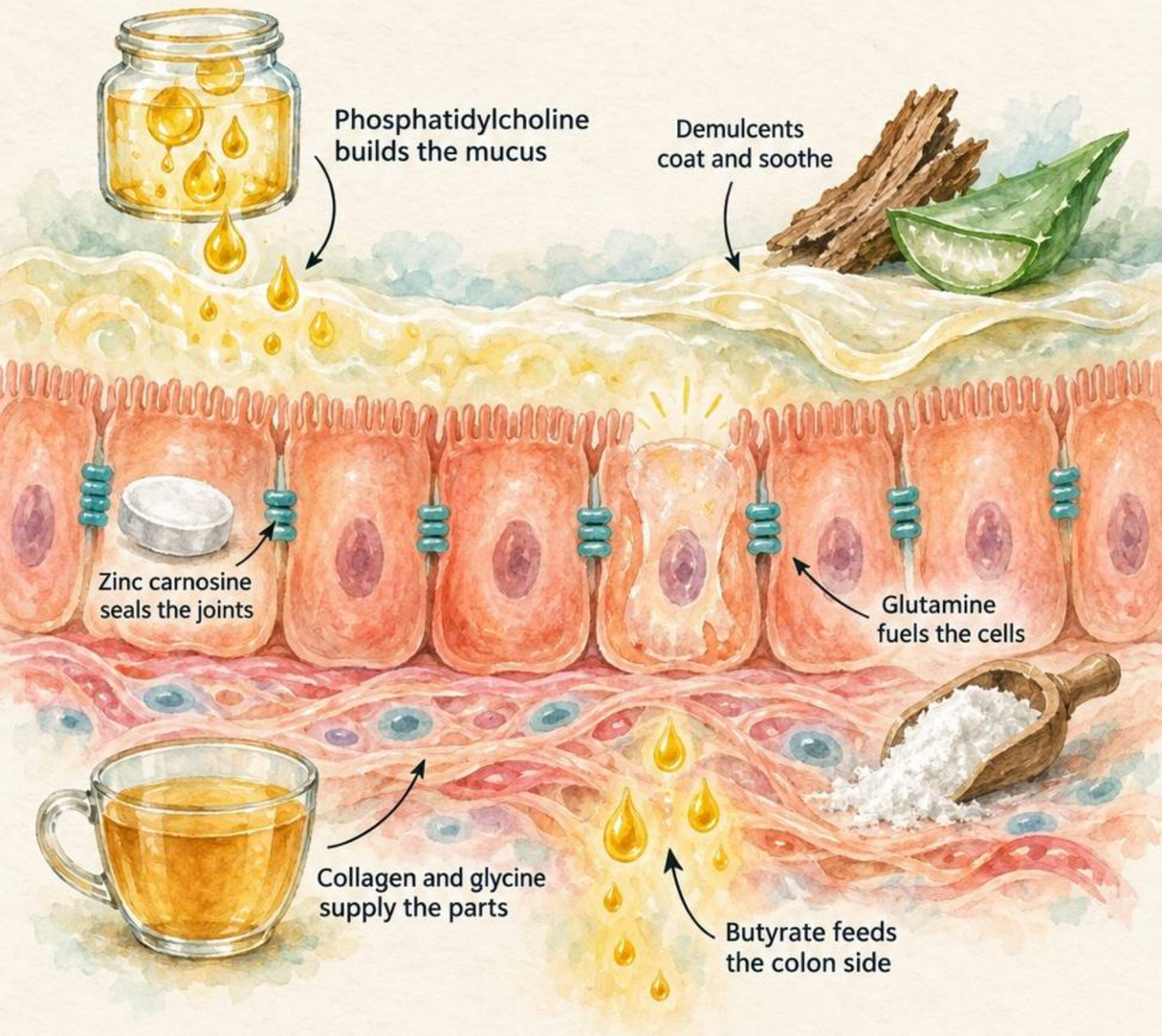
Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/barrier-repair

Illustration: The epithelial wall, its tight junctions and the mucus layer above

Never make changes to your protocol without consulting your gastroenterologist.

How the barrier is rebuilt



The wall is three layers, and each has a raw material. Above the cells sits the mucus, a gel built mostly of phosphatidylcholine and mucin: phosphatidylcholine (F-08) supplies the phospholipid, N-acetylglucosamine (F-06) the mucin's sugar backbone, and the demulcents, slippery elm and aloe, coat the surface while it thickens. Between the cells are the tight junctions, the seals that leak in IBD; zinc carnosine (F-05) and quercetin (A-02) help close them. The cells themselves need fuel: glutamine (F-01) for the enterocyte of the small bowel, butyrate (F-02) for the colonocyte, creatine (F-03) as the ATP buffer, and the glycine and proline of collagen (F-09) as building material for the tissue beneath. Repair is not one move. It is all of these at once, on a wall that is trying to rebuild while inflammation pulls it apart.

Never make changes to your protocol without consulting your gastroenterologist.

Section F · Barrier Repair · highlighted products





Bone broth, meat

F-01 · #51

L-glutamine

Pure Encapsulations, L-Glutamine Powder · 227 g

Barrier

The primary fuel of the small-intestinal lining. Human trials are honest and unflattering: in Crohn's, oral glutamine improved intestinal permeability but no more than a whey-protein control (Benjamin 2012), a long-term trial found no effect on permeability (Den Hond 1999), and a Cochrane review calls the evidence insufficient. The physiology is not in doubt, and neither is the safety. Three grams per scoop, no additives.

Well tolerated. Not for anyone with severe liver or kidney disease without guidance.

References 94–97

Andrew's notes

Crohn's disease: 5. Ulcerative colitis: 2. One of the safest, easiest and best supplements you can use; there are very few risks to it, which is why it earns a 5.

Buy on Fullscript →

go.supplementsforibd.com/glutamine

SKU PUR-LGP

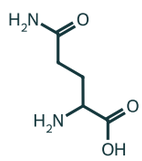
Also Pure Encapsulations l-Glutamine 850 mg capsules, go.supplementsforibd.com/glutamine-capsules

Evidence 3

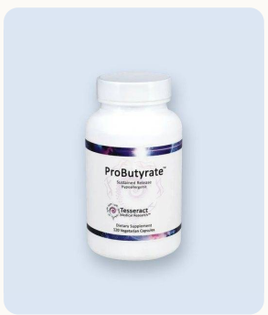
Small RCTs in Crohn's, no advantage over control; strong physiology

Andrew's score 5

Crohn's 5 · UC 2



L-glutamine · $C_5H_{10}N_2O_3$ · 146.1 g/mol · PubChem CID 5961





Butter, ghee

F-02 · #52

Butyrate

Tesseract Medical Research, ProButyrate · 120 caps

Barrier Inflammation Nourish

Butyric acid itself (not the sodium or calcium salt) in a sustained-release form designed to survive the small intestine and reach the colon, which is the entire problem with oral butyrate. Allergen-free. The colonocyte's fuel and an HDAC inhibitor.

Buttery smell is normal. Start low; some people get transient cramping.

Reference 98

Andrew's notes

A super important supplement; it works. Butyrate is a postbiotic, naturally produced by fiber-fermenting bacteria in the large intestine. When we don't get enough fiber, or have to go on a lower-residue diet for a while, we don't make enough of it, and that is where supplementing comes in. Perhaps a little more relevant in ulcerative colitis, but important in Crohn's too.

Buy on Fullscript →

go.supplementsforibd.com/butyrate

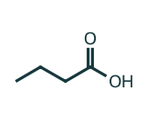
SKU TES617-GI000

Evidence 3

Rectal butyrate RCTs in UC; oral delivery data emerging

Andrew's score 4

Andrew's judgment, 1–5.



Butyrate, as butyric acid · $C_4H_8O_2$ · 88.1 g/mol · PubChem CID 264

Section F · Barrier Repair · highlighted products, continued





Red meat, fish

F-03 · #53

Creatine

Thorne, Creatine · 450 g

Barrier

Creatine monohydrate, the cheapest, best-studied supplement in existence, and the epithelium's ATP buffer. The gut-lining story is strong in cells and mice (creatine-kinase and creatine-transporter expression is lost in IBD tissue, and supplementation protects against colitis in animals), and a 2021 paper by the Colorado group lays out the rationale for a trial. The one registered UC pilot was withdrawn without enrolling anyone, so there is no human IBD trial yet. Five grams per scoop, no additives.

Drink water. Harmless weight gain from muscle water in the first weeks.

References 99–100

Andrew's notes

Creatine has been a genuinely positive part of my own routine, and it matters most to me for training, which is one of the best things I do for my Crohn's. My view is that 2 to 5 g a day is plenty and that the 10 to 15 g doses people take are unnecessary and possibly risky for a gut already under strain; that is my opinion, not a finding that every higher dose is harmful. I take it after a workout out of habit, though the timing evidence is thin and I would not insist on it.

Buy on Fullscript →

go.supplementsforibd.com/creatine

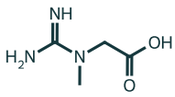
SKU THO-SF903

Evidence 1

Preclinical and single-case only; no completed human IBD trial

Andrew's score 4

Andrew's judgment, 1–5.



Creatine · $C_4H_9N_3O_2$ · 131.1 g/mol · PubChem CID 586





Aloe leaf

F-04 · #54

Aloe vera (inner leaf)

Global Healing, Aloe Vera (inner-leaf, aloin-free) · 2 oz

Barrier Inflammation

Inner-leaf gel, not whole-leaf, which contains aloin, a laxative that irritates IBD guts. In a London double-blind trial (n = 44), 100 mL of aloe gel twice daily for four weeks produced remission in 30% versus 7% on placebo and improvement in 37% versus 7%, with reduced histological activity; the numbers were small and just short of significance. An Italian enema trial is registered. Organic, clean label.

If a product doesn't say aloin-free or inner-fillet, skip it.

References 101–102

Andrew's notes

I have found aloe very helpful, and where I can I prefer a plant or food source over a capsule. Inner-leaf gel is the form that was studied and the form to look for; whole-leaf products contain aloin, a laxative that irritates an IBD gut. Aloe on the skin and aloe swallowed are different questions, and a plant in the garden is not a verified product: if you drink it, buy a preparation whose label says inner fillet and aloin-free.

Buy on Fullscript →

go.supplementsforibd.com/aloe-vera

SKU GLH055-811839030294

Evidence 3

One small RCT in UC, favorable but underpowered

Andrew's score 3

Andrew's judgment, 1–5.

Section F · Barrier Repair · highlighted products, continued





Shellfish, the source of chitin

F-06 · #56

N-acetylglucosamine (NAG)

Allergy Research Group, N-Acetyl Glucosamine 500 mg · 90 caps

Barrier

The amino sugar the gut uses to build mucin, the mucus layer itself. In a London pilot, 8 of 12 children with severe, treatment-resistant IBD improved on NAG (oral, or by enema for colonic disease), with thickening of the glycosaminoglycan layer on biopsy; an open-label adult series later reported symptom improvement in a third to two-thirds of patients on 6 g/day. It is one of the very few things that directly feeds mucus production. Vegan source, clean label.

Vegan source, but check with a severe shellfish allergy.
References 105–106

Andrew's notes

NAG gives a mild benefit in my experience. It is not a supplement I take regularly, but it is one I keep available for the times the mucus layer feels like the part that needs help. I have not seen problems with it, which is not the same as knowing there are none.

Buy on Fullscript →

go.supplementsforibd.com/nag

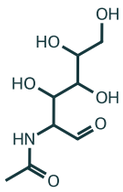
SKU ARG-71140

Evidence 3

Pediatric IBD pilot

Andrew's score 3

Andrew's judgment, 1–5.



N-acetylglucosamine · $C_8H_{15}NO_6$ · 221.2 g/mol · PubChem CID 1738118





Egg yolk, sunflower

F-08 · #58

Phosphatidylcholine

BodyBio, PC (phosphatidylcholine) · 100 softgels

Barrier Inflammation

The phospholipid that makes up most of the colonic mucus layer, and is measurably depleted in UC. A delayed-release PC (LT-02) had three positive Heidelberg trials in chronic active UC (pooled remission odds ratio 9.7), then a 466-patient phase 3 program was stopped for futility in 2023: deep remission 14% on LT-02 versus 13.5% on placebo. It was never sold. Neither supplement here is delayed-release: BodyBio is a liposomal phospholipid complex, Thorne a standard softgel. The biology holds; the trial form does not exist to buy.

Both soy-derived. Loose stool at high doses.
References 109–112

Andrew's notes

A 4 rather than a 5 only because of the negative trial. I continue to see good results and have never seen anything negative. I do wonder whether any downside comes from the same kind of oxidative stress we worry about with seed oils. Two products here; neither is a delayed-release formulation, and the one that was (LT-02) was a drug candidate that never reached the market.

Buy on Fullscript →

go.supplementsforibd.com/phosphatidylcholine

SKU KAN-SP600

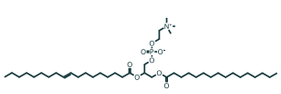
Also Thorne Phosphatidyl Choline, go.supplementsforibd.com/phosphatidylcholine-2

Evidence 3

Positive early UC trials of a drug form; a negative phase 3

Andrew's score 4

Andrew's judgment, 1–5.



A phosphatidylcholine (POPC) · $C_{42}H_{82}NO_8P$ · 760.1 g/mol · PubChem CID 5497103

Section F · Barrier Repair · highlighted products, continued





Bone broth

F-09 · #59

Collagen peptides

Vital Proteins, Collagen Peptides, Unflavored · 284 g

Barrier · Replenish

Glycine, proline and hydroxyproline, the raw materials for connective tissue and the gut lining. No IBD trials; it's here as a well-tolerated protein source that dissolves in anything and gives the barrier what it's built from.

Bovine source. Unflavored is the one to buy, flavored versions carry sweeteners.

Reference 113

Andrew's notes

Collagen is a super protein source for people with IBD, very nutrient-dense and easy to tolerate, and it dissolves in a smoothie or a broth without changing the taste. It will not reduce inflammation much, and it is not a treatment for IBD; it is raw material for the connective tissue and the lining. I find it especially useful for people with Crohn's who have joint issues.

Buy on Fullscript →

go.supplementsforibd.com/collagen

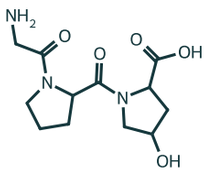
SKU VIT360-CP10W

Evidence 1

Preclinical; nutritional rationale

Andrew's score 4

Andrew's judgment, 1–5.



Gly-Pro-Hyp, the collagen tripeptide · $C_{12}H_{19}N_3O_5$ · 285.3 g/mol · PubChem CID 11778669





Elm bark

F-10 · #60

Slippery elm

Vital Nutrients, Slippery Elm Bark Powder · 175 g

Barrier

A demulcent, it coats. The mucilage soothes irritated lining on contact, and biopsy studies found antioxidant activity in UC tissue. One of the oldest gut remedies there is, and one of the cheapest. The featured product is the plain inner-bark powder, 2.5 g per rounded teaspoon and nothing else on the label, which you stir into warm water: the closest thing to the traditional tea, and the form I prefer. The capsules below are the travel option.

Take separately from medications, it can slow their absorption.

Reference 114

Andrew's notes

Personally I would take slippery elm as a tea, which is how it has been used for centuries. If you are traveling or need it in capsule form, this is where you go. Take it apart from medications, because the mucilage can slow their absorption.

Buy on Fullscript →

go.supplementsforibd.com/slippery-elm

SKU VN-SLP

Also NOW Foods Slippery Elm 400 mg, go.supplementsforibd.com/slippery-elm-capsules

Evidence 2

Traditional use; UC biopsy antioxidant data

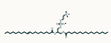
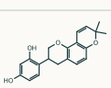
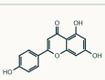
Andrew's score 3

Andrew's judgment, 1–5.

Section F · Barrier Repair

All 13 entries, with links

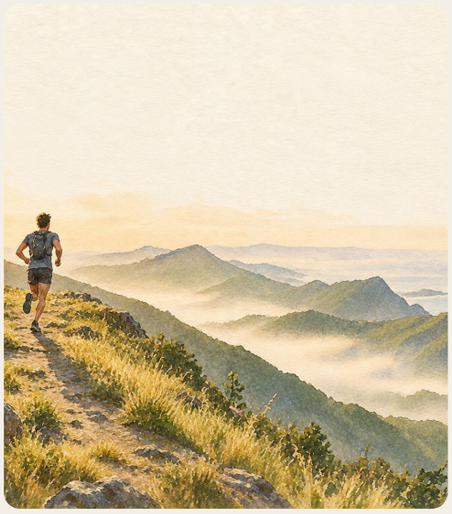
★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
51	F-01	★ **L-glutamine** ● Barrier		Evidence ■■■□□ 3 Andrew ■■■■■ 5	Pure Encapsulations L-Glutamine Powder; Pure Encapsulations l-Glutamine 850 mg capsules go.supplementsforibd.com/glutamine go.supplementsforibd.com/glutamine-capsules	Enterocyte fuel References 94–97
52	F-02	★ **Butyrate** ● Barrier		Evidence ■■■□□ 3 Andrew ■■■■□ 4	Tesseract Medical Research ProButyrate go.supplementsforibd.com/butyrate	Colonocyte fuel; the delivery problem Reference 98
53	F-03	★ **Creatine** ● Barrier		Evidence ■□□□□ 1 Andrew ■■■■□ 4	Thorne Creatine go.supplementsforibd.com/creatine	Epithelial ATP buffer References 99–100
54	F-04	★ **Aloe vera (inner leaf)** ● Barrier		Evidence ■■■□□ 3 Andrew ■■■□□ 3	Global Healing Aloe Vera (inner-leaf, aloin-free) go.supplementsforibd.com/aloe-vera	Randomized UC trial (inner-leaf gel) References 101–102
55	F-05	**Zinc carnosine** ● Barrier		Evidence ■■■□□ 3 Andrew —	Integrative Therapeutics Zinc-Carnosine (PepZinGI) go.supplementsforibd.com/zinc-carnosine	Andrew wants this one emphasized: a zinc-carnosine chelate that stays in contact with the gut lining, developed in Japan as an ulcer drug (polaprezinc). In a London crossover trial, 37.5 mg twice daily completely prevented the threefold rise in gut permeability that five days of indomethacin caused in volunteers, and it stimulated gut-cell repair in the lab; a later trial paired it with colostrum against exercise-induced leak. One of the few entries with human data on the tight junctions themselves; no IBD trial yet. Contains magnesium stearate. References 103–104
56	F-06	★ **N-acetylglucosamine (NAG)** ● Barrier		Evidence ■■■□□ 3 Andrew ■■■□□ 3	Allergy Research Group N-Acetyl Glucosamine 500 mg go.supplementsforibd.com/nag	Amino sugar for mucin synthesis References 105–106
57	F-07	**Bovine colostrum** ● Barrier		Evidence ■■■■□ 4 Andrew —	Pure Encapsulations Colostrum go.supplementsforibd.com/colostrum	A small randomized trial of bovine colostrum enemas added to mesalazine in left-sided colitis improved symptom and histology scores over four weeks. Oral colostrum brings growth factors and antibodies; contains milk. References 107–108
58	F-08	★ **Phosphatidylcholine** ● Barrier		Evidence ■■■□□ 3 Andrew ■■■■□ 4	BodyBio PC (phosphatidylcholine); Thorne Phosphatidyl Choline go.supplementsforibd.com/phosphatidylcholine go.supplementsforibd.com/phosphatidylcholine-2	Mucus-layer phospholipid depleted in UC References 109–112
59	F-09	★ **Collagen peptides** ● Barrier		Evidence ■□□□□ 1 Andrew ■■■■□ 4	Vital Proteins Collagen Peptides, Unflavored go.supplementsforibd.com/collagen	Glycine/proline substrate Reference 113
60	F-10	★ **Slippery elm** ● Barrier		Evidence ■■□□□ 2 Andrew ■■■□□ 3	Vital Nutrients Slippery Elm Bark Powder; NOW Foods Slippery Elm 400 mg go.supplementsforibd.com/slippery-elm go.supplementsforibd.com/slippery-elm-capsules	Demulcent mucilage Reference 114
61	F-11	**Marshmallow root** ● Barrier		Evidence ■□□□□ 1 Andrew —	no product —	Demulcent mucilage, traditional for irritated lining. Covered inside DGL Plus.
62	F-12	**DGL licorice** ● Barrier		Evidence ■□□□□ 1 Andrew —	Pure Encapsulations DGL Plus go.supplementsforibd.com/dgl	Deglycyrrhizinated licorice protects mucosa without the blood-pressure effect of whole licorice. Note: some people find DGL irritating rather than soothing; if it bothers you, stop. Reference 115
63	F-13	**Chamomile** ● Barrier		Evidence ■■■□□ 3 Andrew —	no product —	Apigenin and bisabolol; spasmolytic and mildly anti-inflammatory. A German double-blind trial (n = 96) found a myrrh, chamomile and coffee-charcoal preparation non-inferior to mesalazine for maintaining UC remission over 12 months. As a single herb, a tea is the sensible form. References 116–117

Section F · Barrier Repair · a designed module

Exercise, the barrier and vitamin C

Hard training is one of the best things I do for my Crohn's, and for a few hours after it, my gut wall is more permeable than usual. Here is one helpful tip for living with both.



THE MECHANISM

Intense exercise transiently loosens the gut barrier

During hard exercise, blood is shunted from the gut to the muscles and the skin. The epithelium runs briefly short of oxygen and fuel, tight junctions loosen, and for a few hours intestinal permeability rises; markers of it appear in the blood of healthy athletes after a hard session. Heat makes it worse. In a healthy gut this closes on its own. In a gut that is already leaky, it is worth blunting.

THE TIP

Vitamin C before training. In a small study of healthy volunteers, oral vitamin C (1,000 mg a day) abolished the rise in blood endotoxin, bacterial material that crosses the gut wall, after maximal exercise, along with the oxidative stress that drives it. That is an indirect marker in healthy people, not permeability measured directly and not a trial in IBD, so read it as a plausible habit rather than a proven one. I first read about it in the Briggs paper. I take a buffered powder in cold water before I train, every other day, and it has become one of the cheapest, most boring, most useful habits in my regimen; vitamin C is J-12 in this guide, and the products are below. (refs 180–181)



THE POWDER I TAKE · J-12

PERQUE Potent C Guard Powder · 227 g

Fully buffered ascorbates, 1,584 mg of vitamin C per rounded half-teaspoon with potassium, calcium, magnesium and zinc as the buffers, and nothing else on the label; it effervesces in cold water. SKU PER-252.

Buy on Fullscript →

go.supplementsforibd.com/potent-c-guard



THE PILL ALTERNATIVE · J-12

PERQUE Potent C Guard 1000 mg Tabsules · 100

The same buffered L-ascorbate as a 1,000 mg tablet, buffered with calcium and magnesium, with a small amount of organic croscarmellose (a plant fiber) as the only other ingredient. For travel, or for people who would rather not mix a powder. SKU PER-138.

Buy on Fullscript →

go.supplementsforibd.com/potent-c-guard-tablets

What else protects the wall during training

Hydration and electrolytes, above all. Eating two or three hours before, not right before. Training in the cool part of the day. Glutamine (F-01) has small studies in athletes for the same permeability endpoint. And a gentler week when your disease is active: in a flare, walks, yoga and mobility work do what the hard sessions cannot.

Why I train anyway

Because the other direction is bigger. Regular exercise lowers baseline inflammation, improves sleep, protects the bone that steroids and disease erode, and in cohort studies people with IBD who exercise flare less. The transient leak is a cost worth paying, and worth paying for wisely. My goal is to be the kind of person who can still exercise with his great-grandchildren.



G

SECTION G · 2 ENTRIES · 2 WITH A PRODUCT

Peptides

Two entries, one product, and a section I wrote with more care than any other. Peptides have exploded in the IBD community; BPC-157 and KPV have been known for a long time, and both have deep animal literatures showing faster healing of the gut lining, less TNF-alpha at the wound and new vessel growth beneath it. What they do not have is a randomized human trial, published pharmacokinetics for the oral forms, or a regulatory status that stays still from one year to the next. That combination makes them the part of this guide most likely to read as medicine rather than nutrition, and the part where I ask you to be most careful, most honest with your medical team, and most skeptical of a vial that promises more than the literature does. The mechanism page that follows explains what is known and what is hoped, and the cards say exactly where the evidence bars sit.

IN THIS SECTION, WITH A PRODUCT

BPC-157 70 **KPV** 70

Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/peptides

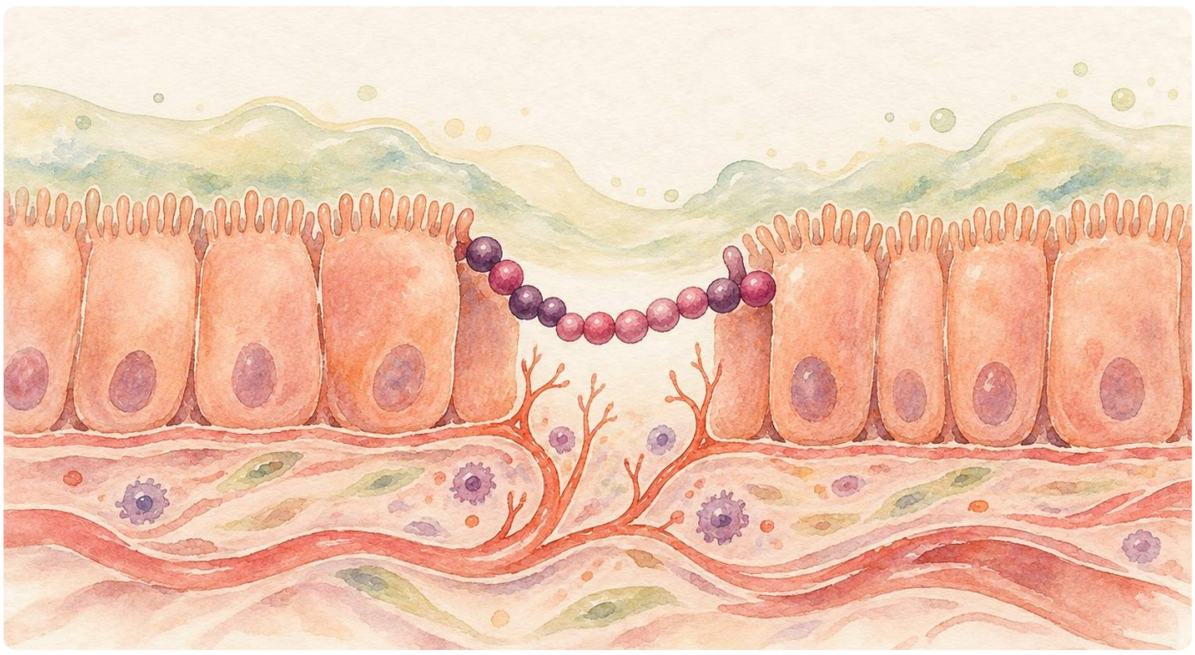
Illustration: A peptide chain

Never make changes to your protocol without consulting your gastroenterologist.

Section G · Peptides · the mechanism, and the gap

How a repair peptide is thought to work

Peptides have exploded. They are everywhere in the IBD community, and BPC-157 and KPV have been known for a long time. The evidence needs to catch up with the enthusiasm, and there is likely more risk with specific peptides than with anything else in this guide. Read this page before the two cards.



How a repair peptide is thought to work. A short chain of amino acids (BPC-157 is fifteen, KPV is three) survives digestion better than most proteins, binds receptors and growth-factor pathways rather than being consumed, and in animal models drives new vessel growth and faster closure of the epithelial gap while lowering TNF-α at the wound. The picture is painted from animal and cell studies; no randomized human trial of either peptide exists in IBD.

Why the risk is different

A polyphenol from a food has a safety record measured in centuries of dinners. A synthetic peptide has one measured in years of enthusiasts. BPC-157 is on the World Anti-Doping Agency's prohibited list and, at the time of writing, is not an approved drug in any country I am aware of; US regulators have moved against compounded versions; the quality of what arrives in a vial or a capsule varies with the supplier and cannot be checked at home. None of that makes the molecules bad. It makes them the part of this guide where I ask you to be most careful, most honest with your team, and most skeptical of a bottle that promises more than the literature does.

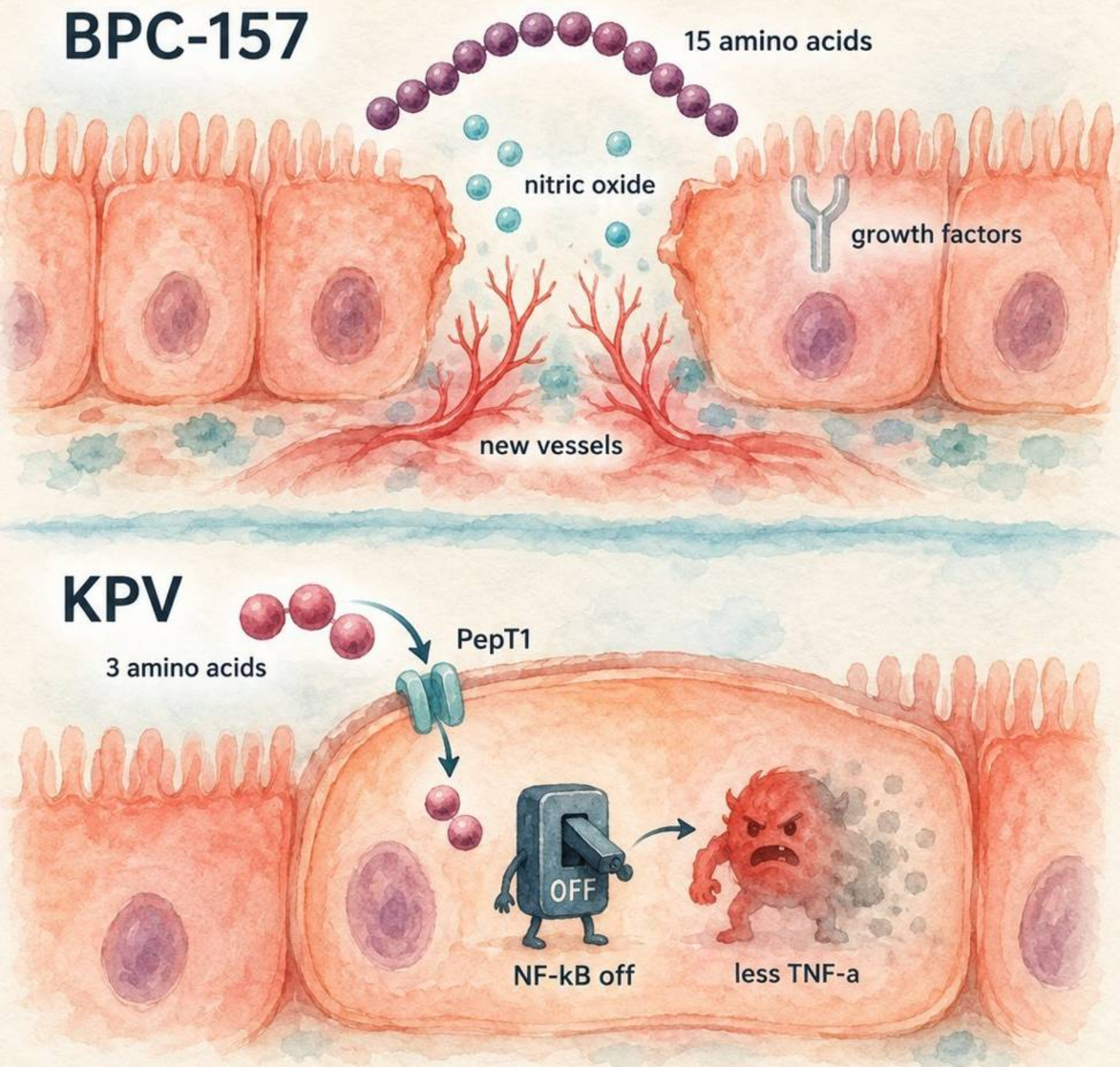
An ask for the scientific community

I have followed peptides for more than a decade, and I see both the hype and the potential; I am still exploring the evidence, and I am not settled. What would let me widen this section: a randomized trial in people, in either disease, on a validated endpoint. Published pharmacokinetics for the oral forms, so a milligram on a label means something. Third-party testing you can read. And a regulatory status that is not moving under our feet. I prefer to discuss oral forms here because that is what people actually buy, which is not a statement that they are safe. Until then, two entries, one product, two structures on the following page, and a clear statement of what is known and what is hoped.

The stearate contradiction, in print

The only other BPC-157 source I have found on Fullscript contains vegetable stearate, which Section K treats as a tiebreaker against a product. I have not resolved that tension; it stays visible here rather than hidden.

Two peptides, two mechanisms



BPC-157 is a chain of fifteen amino acids. In animal studies it raises nitric oxide, recruits growth-factor signaling and drives new blood vessels toward a wound, which is how a torn lining closes faster in rats. KPV is three amino acids, the anti-inflammatory tail of the hormone alpha-MSH. Inflamed gut-lining cells take it up through PepT1, a doorway in the cell membrane that normally carries tiny protein fragments from digested food into the cell, and which inflamed colon cells make far more of; once inside, in cell and colitis-model studies, KPV switches off NF-κB and lowers TNF-α. Both pictures come from animal and cell studies. Neither peptide has a randomized human trial in IBD, published pharmacokinetics for the oral forms, or a settled regulatory status. Read the cards before the vial.

Never make changes to your protocol without consulting your gastroenterologist.

Section G · Peptides · highlighted products



G-01 · #64

BPC-157

Quicksilver Scientific, BPC + KPV Combo · 50 mL

Barrier · Inflammation

BPC-157 is a fifteen-amino-acid fragment of a protein found in gastric juice, with an enormous animal literature on mucosal, tendon and vascular repair, nearly all of it from one group in Zagreb. The human record is thin and mostly unpublished: UC enema trials run by a Croatian drug company in the 2000s were never fully reported, and a 2015 oral safety study's data were withdrawn from the trial registry. It is not approved by any regulator and the US military lists it as prohibited. This liposomal liquid pairs it with KPV (next card) and is the clean option: no vegetable stearate.

Investigational. Regulatory status is in flux; sold as a supplement today. Weigh the animal data against the absence of published human trials.

References 118–121

Andrew's notes

I have seen great effects, personally and in others, and I have known about BPC-157 for a long time. Many people have now taken it and I have not seen serious harm; that is reassurance, not a safety profile, and safety is still being studied in all peptides. This is the part of the guide where I ask you to be most careful and most honest with your team.

Buy on Fullscript →

go.supplementsforibd.com/bpc-kpv

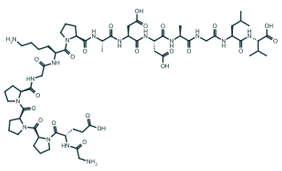
SKU QSL-Q1246

Evidence 1

Animal data deep; published human data essentially absent

Andrew's score 4

Andrew's judgment, 1–5.



BPC-157, fifteen amino acids · $C_{62}H_{98}N_{16}O_{22}$ · 1419.6 g/mol



G-02 · #65

KPV

Quicksilver Scientific, BPC + KPV Combo · 50 mL

Inflammation · Barrier

KPV is the three-amino-acid anti-inflammatory tail of alpha-MSH. It is taken up directly by inflamed intestinal epithelium through the PepT1 transporter, and in colitis models it lowers NF-kB signaling and inflammatory cytokines. Human data are anecdotal so far. Same product as BPC-157: the two travel together in this liquid.

Investigational; safety still being established for all oral peptides.

Reference 122

Andrew's notes

I have heard very good reports about KPV from people who use it, and I am interested in hearing more of them; I have not established anything about its comparative safety, and online reports are not clinical results. My own experience with the combination is still forming. If the safety picture becomes clearer I expect to revisit the score, and I would be glad to widen this section when the evidence allows.

Buy on Fullscript →

go.supplementsforibd.com/bpc-kpv

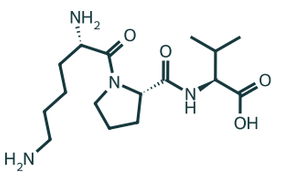
SKU QSL-Q1246

Evidence 1

Preclinical; anecdotal human reports

Andrew's score 3

Andrew's judgment, 1–5.

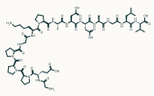
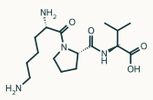


KPV, lysine-proline-valine · $C_{16}H_{30}N_4O_4$ · 342.4 g/mol

Section G · Peptides

All 2 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
64	G-01	★ **BPC-157** ● Barrier		Evidence ■□□□□ 1 Andrew ■■■■□ 4	Quicksilver Scientific BPC + KPV Combo go.supplementsforibd.com/bpc-kpv	Pentadecapeptide; animal data deep, human thin References 118–121
65	G-02	★ **KPV** ● Inflammation		Evidence ■□□□□ 1 Andrew ■■■□□ 3	Quicksilver Scientific BPC + KPV Combo go.supplementsforibd.com/bpc-kpv	α-MSH tripeptide; preclinical Reference 122



H

SECTION H · 8 ENTRIES · 4 WITH A PRODUCT

Digestive Support & Enzymes

Eight entries with almost no IBD trial evidence, and one clear exception: peppermint oil leads because it is one of the best-evidenced treatments for IBS-type cramping, and IBS-type symptoms in people whose IBD is quiet are extremely common. The rest of the section is about a different problem than inflammation: a gut that is not digesting well. Enzymes from papaya and pineapple, broad-spectrum digestive enzymes, lactase and alpha-galactosidase for the specific sugars that ferment, DAO for histamine, and betaine for the stomach acid that many people with long-standing disease or on acid blockers no longer make enough of. None of these change the course of IBD; several change how the next meal feels, and a body that can digest what it eats has more to repair itself with. Everything here can be taken before, with, between or after meals; experiment with timing. Four highlighted.

IN THIS SECTION, WITH A PRODUCT

Peppermint oil 73 **Digestive enzymes** 73 **Papain** 74 **Bromelain** 74

Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/digestive-support

Illustration: Papaya, pineapple and peppermint

Never make changes to your protocol without consulting your gastroenterologist.

Section H · Digestive Support & Enzymes · highlighted products





Peppermint leaf

H-01 · #66

Peppermint oil (enteric-coated)

Protocol for Life Balance, Peppermint Oil G.I. (enteric-coated) · 90 softgels

Modulate

The only entry in this section with a real randomized-trial base: in IBS, a meta-analysis of seven placebo-controlled trials found enteric-coated peppermint oil more than doubled the odds of global improvement (number needed to treat, three), though a 2022 update rated the evidence quality very low and counted more side effects. Enteric coating is the whole point: released too early it causes reflux. With ginger and fennel.

Heartburn after a dose means the coating failed. Contains soybean oil.

References 123–125

Andrew's notes

Peppermint is really nice after a meal, and for me that usually means a cup of peppermint tea rather than a capsule; the enteric-coated capsule is the form the IBS trials used and the form I travel with. Tea and the coated oil are not interchangeable, and I do not think either changes the course of IBD. They change how the next hour feels, which on some days is the whole point.

Buy on Fullscript →

go.supplementsforibd.com/peppermint-oil

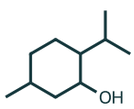
SKU PROT-P4727

Evidence 2

Strong IBS RCTs; no IBD trials

Andrew's score 2

Andrew's judgment, 1–5.



Menthol · $C_{10}H_{20}O$ · 156.3 g/mol · PubChem CID 1254



H-02 · #67

Broad-spectrum digestive enzymes

Pure Encapsulations, Digestive Enzymes Ultra · 90 caps

Modulate

Broad-spectrum plant enzymes, proteases, amylase, lipase, lactase, alpha-galactosidase and more. Exocrine pancreatic insufficiency is underdiagnosed in IBD, and many people with active small-bowel disease digest poorly. Covers H-06 too.

If you feel dramatically better on these, ask your GI about a fecal elastase test.

References 126–127

Andrew's notes

See how you feel as you take these. Digestive enzymes are generally not affecting inflammation or the direct mechanisms of IBD; they help you digest, and for some people that difference is large. If you feel dramatically better on them, tell your gastroenterologist, because it can point to pancreatic insufficiency worth testing for.

Buy on Fullscript →

go.supplementsforibd.com/digestive-enzymes

SKU PUR-DEU9

Also Klaire Labs / SFI Health Ther-Biotic Vital-Zymes Complete, go.supplementsforibd.com/vital-zymes

Evidence 2

Adjacent data; clinical rationale

Andrew's score 3

Andrew's judgment, 1–5.

Section H · Digestive Support & Enzymes · highlighted products, continued





Papaya

H-03 · #68

Papain (papaya enzyme)

Enzymedica, Papaya Complete · 120 tabs

Modulate

Papain from papaya plus bromelain, in a chewable-style tablet, the closest thing on Fullscript to the classic papaya enzyme. Gentle proteases taken with meals.

Contains xylitol, which loosens some people's stool.

Reference 128

Andrew's notes

Papaya enzymes are very helpful for people in my experience, and I keep a chewable on hand for after meals, particularly after a heavy or unfamiliar one. My own preferred chewable is American Health's Super Papaya Enzyme Plus, a grocery-store and pharmacy product that is not on Fullscript, so the Enzymedica tablet is the one linked here; both carry sugar alcohols (xylitol in one, sorbitol and mannitol in the other) that loosen some people's stool. They help you digest; they do not treat the disease.

Buy on Fullscript →

go.supplementsforibd.com/papaya-enzyme

SKU EZM942-1010118

Evidence 1

Traditional; enzyme rationale

Andrew's score 4

Andrew's judgment, 1–5.





Pineapple stem

H-04 · #69

Bromelain

Pure Encapsulations, Bromelain 2400 · 180 caps

Inflammation Modulate

Pineapple-stem protease. With food it digests protein; between meals it's absorbed and acts as an anti-inflammatory, with case reports in UC. 500 mg at 2,400 GDU, a serious dose.

Additive with anticoagulants. Pineapple allergy.

References 129–131

Andrew's notes

I expected more evidence for bromelain than exists, and I have still observed digestive benefit with it, which is why my score sits where it does. With food it helps digest protein; between meals it is absorbed and has anti-inflammatory activity in other conditions. The IBD evidence is case reports, and the card says so.

Buy on Fullscript →

go.supplementsforibd.com/bromelain

SKU PUR-BR51

Evidence 2

Case reports in UC; adjacent RCTs

Andrew's score 4

Andrew's judgment, 1–5.

Section H · Digestive Support & Enzymes

All 8 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
66	H-01	★ **Peppermint oil (enteric-coated)** Modulate		Evidence 2 Andrew 2	Protocol for Life Balance Peppermint Oil G.I. (enteric-coated) go.supplementsforibd.com/peppermint-oil	The only entry here with a real trial base References 123–125
67	H-02	★ **Broad-spectrum digestive enzymes** Modulate		Evidence 2 Andrew 3	Pure Encapsulations Digestive Enzymes Ultra; Klaire Labs / SFI Health Ther-Biotic Vital-Zymes Complete go.supplementsforibd.com/digestive-enzymes go.supplementsforibd.com/vital-zymes	Pancreatic insufficiency is underdiagnosed in IBD References 126–127
68	H-03	★ **Papain (papaya enzyme)** Modulate		Evidence 1 Andrew 4	Enzymedica Papaya Complete go.supplementsforibd.com/papaya-enzyme	Plant protease Reference 128
69	H-04	★ **Bromelain** Inflammation		Evidence 2 Andrew 4	Pure Encapsulations Bromelain 2400 go.supplementsforibd.com/bromelain	Pineapple protease References 129–131
70	H-05	**Lactase** Modulate		Evidence 2 Andrew —	no product —	Secondary lactose intolerance is common in active small-bowel disease and often resolves in remission. No clean standalone product matched; the enzyme blend (H-02) includes lactase.
71	H-06	**Alpha-galactosidase** Modulate		Evidence 2 Andrew —	no product —	Breaks down the oligosaccharides in legumes that cause gas. Included in the enzyme blend (H-02).
72	H-07	**Diamine oxidase (DAO)** Inflammation		Evidence — Andrew —	Omne Diem Histamine Digest (DAO) go.supplementsforibd.com/dao	Histamine-degrading enzyme Reference 132
73	H-08	**Betaine HCl** Modulate		Evidence 1 Andrew —	no product —	Gastric acid support; no IBD evidence and it conflicts with acid-suppressing medication. No product matched.



I

SECTION I · 5 ENTRIES · 1 WITH A PRODUCT

Amino Acids

Five entries, one product, and a caution that runs through the whole section. Glutamine, the amino acid that matters most in IBD, has its home in Barrier Repair (F-01), and its card is repeated in this section, powder and capsules, because this is where people look for it; in my experience it matters most in Crohn's disease, where the small-bowel lining runs on it, and the human trials are mixed, which the card says plainly. The others earn their place when the gut is not digesting protein well, which is when a free-form complex can deliver what a steak cannot: tryptophan for the serotonin and the indole compounds that talk to the wall, arginine for blood flow and repair, glycine for collagen and the bile acids, histidine for the carnosine that pairs with zinc in F-05. Then the sulfur amino acids, cysteine and methionine, which need a warning of their own. Sulfur is not harmless in a colon that is already inflamed: sulfate-reducing bacteria turn it into hydrogen sulfide, a gas that is toxic to colonocytes at high concentration, blocks butyrate use, and is found at higher levels in ulcerative colitis. High-sulfur supplementation, and high-sulfur diets, can feed exactly the wrong organisms. The sulfur amino acids stay in the list because the body needs them and because NAC (C-10) and glutathione (C-11) are built from them; the caution is in the note, and it is meant seriously.

IN THIS SECTION, WITH A PRODUCT

Tryptophan 77

Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/amino-acids

Illustration: Free-form amino acids as linked building blocks

Never make changes to your protocol without consulting your gastroenterologist.

Section I · Amino Acids · highlighted products





Pumpkin seeds. If you have strictures or active disease, blend or grind them rather than eating them whole

I-01 · #74

Tryptophan

Thorne, Amino Complex (Berry) NSF · 231 g

Nourish · Replenish · Inflammation

The one amino-acid product for the section: all essential amino acids in free form, including tryptophan, histidine and the sulfur amino acids that entries I-01 through I-05 describe. Free-form aminos need no digestion, useful when the gut isn't digesting protein well. Pumpkin seeds, pictured, are one of the richest food sources of tryptophan and the other amino acids here; a food-first note on tolerance: in active disease, and especially with a stricture, whole seeds and nuts are a poor idea, and blending them into a smoothie or using a seed butter is the gentler route, a question of texture and disease activity rather than a rule for everyone.

Stevia-sweetened. Not a protein replacement; a supplement to one.

References 133–134

Andrew's notes

Very few side effects; it won't hurt, but the likely efficacy is lower than other interventions here. Add it to your smoothie, or to your creatine or glutamine. Think of it in many ways as a fueling source. It may have mild calming effects.

Buy on Fullscript →

go.supplementsforibd.com/amino-complex

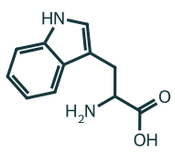
SKU THO-SP641

Evidence 2

Nutritional rationale; adjacent data

Andrew's score 3

Andrew's judgment, 1–5.



L-tryptophan · $C_{11}H_{12}N_2O_2$ · 204.2 g/mol · PubChem CID 6305

REPEATED FROM SECTION F · BARRIER REPAIR · THE AMINO ACID THAT MATTERS MOST IN IBD





Bone broth, meat

F-01 · #51

L-glutamine

Pure Encapsulations, L-Glutamine Powder · 227 g

Barrier

The primary fuel of the small-intestinal lining. Human trials are honest and unflattering: in Crohn's, oral glutamine improved intestinal permeability but no more than a whey-protein control (Benjamin 2012), a long-term trial found no effect on permeability (Den Hond 1999), and a Cochrane review calls the evidence insufficient. The physiology is not in doubt, and neither is the safety. Three grams per scoop, no additives.

Well tolerated. Not for anyone with severe liver or kidney disease without guidance.

References 94–97

Andrew's notes

Crohn's disease: 5. Ulcerative colitis: 2. One of the safest, easiest and best supplements you can use; there are very few risks to it, which is why it earns a 5.

Buy on Fullscript →

go.supplementsforibd.com/glutamine

SKU PUR-LGP

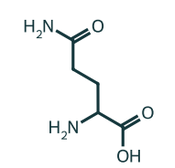
Also Pure Encapsulations l-Glutamine 850 mg capsules, go.supplementsforibd.com/glutamine-capsules

Evidence 3

Small RCTs in Crohn's, no advantage over control; strong physiology

Andrew's score 5

Crohn's 5 · UC 2

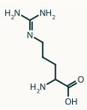


L-glutamine · $C_5H_{10}N_2O_3$ · 146.1 g/mol · PubChem CID 5961

Section I · Amino Acids

All 5 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
74	I-01	★ **Tryptophan** Nourish		Evidence ■■□□□ 2 Andrew ■■■□□ 3	Thorne Amino Complex (Berry) NSF go.supplementsforibd.com/amino-complex	Indole metabolites, AhR signaling References 133–134
75	I-02	**Arginine** Barrier		Evidence ■□□□□ 1 Andrew —	no product —	Nitric oxide precursor with wound-healing roles; preclinical colitis data only.
76	I-03	**Glycine** Inflammation		Evidence ■□□□□ 1 Andrew —	no product —	Anti-inflammatory and cytoprotective in animal models; abundant in collagen and bone broth (F-09).
77	I-04	**Sulfur amino acids** Inflammation		Evidence ■□□□□ 1 Andrew —	no product —	Cysteine and methionine feed glutathione synthesis; see NAC (C-10). Preclinical only. Caution: sulfur amino acids are converted by sulfate-reducing gut bacteria into hydrogen sulfide, which is toxic to colonocytes at high concentration and runs higher in ulcerative colitis. Do not supplement these in isolation during active colitis, and keep dietary sulfur in mind.
78	I-05	**Histidine** Inflammation		Evidence ■□□□□ 1 Andrew —	no product —	Depleted in Crohn's disease in observational studies; protective in colitis models.

A small warning about sulfur

Cysteine, methionine, taurine, and the sulfur-rich foods and supplements built from them (NAC, glutathione, MSM, garlic, eggs, cruciferous vegetables in quantity) are handled in the colon by sulfate-reducing bacteria that make hydrogen sulfide. In a healthy colon the epithelium detoxifies it. In an inflamed one, especially in ulcerative colitis, the gas accumulates, blocks butyrate use by colonocytes and adds to the inflammation. This is not a reason to fear protein; it is a reason not to pile sulfur on top of an active colitis, to introduce sulfur-containing supplements one at a time, and to watch what they do. Three words that get confused: **sulfur** is the element, present in these amino acids; **sulfate** is what the bacteria reduce, and it is also added to some foods; **sulfites** are preservatives in wine, dried fruit and some medications, and a sulfite sensitivity is a separate matter from the colonic sulfur story above. People who react to wine are usually reacting to sulfites, histamine or alcohol itself, not to the sulfur amino acids in their dinner.



J

SECTION J · 22 ENTRIES · 3 WITH A PRODUCT

Vitamins & Minerals

Twenty-two entries. One multivitamin covers most of them; individual products for the deficiencies IBD actually produces, iron, B12, folate, zinc, magnesium, D (in the Five), and the rest. This section is about repletion, not mechanism, and it's where the tracking sheet matters most. Inflammation, diarrhea, a restricted diet, surgery and several IBD medications each drain specific nutrients, and the deficiencies are common: iron and vitamin D in most people at some point, B12 after ileal disease or resection, zinc and magnesium whenever stool is loose. Low levels cause fatigue, poor healing and low mood that are easy to blame on the disease itself. So the order here is food first, a lab test second, and a bottle third, chosen in the form that a sore gut absorbs and tolerates; the map on the next page shows where each nutrient crosses into you, and the page after it explains why most of these entries carry my dash rather than a score.

IN THIS SECTION, WITH A PRODUCT

The multivitamin 82 Iron 82 Vitamin E 83

Browse this whole section in my Fullscript dispensary

go.supplementsforibd.com/vitamins-minerals

Illustration: Minerals and the nutrients IBD drains

Never make changes to your protocol without consulting your gastroenterologist.

Where each nutrient crosses into you



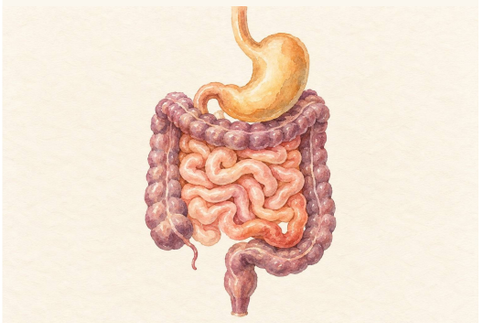
Absorption is a map before it is a list. The stomach starts the work: acid frees vitamin B12 from protein and begins to make iron absorbable. The duodenum, the first stretch of the small intestine, is where iron, calcium, magnesium, zinc and folate cross, and where the fat-soluble vitamins A, D, E and K cross with fat. The jejunum takes up amino acids, sugars and most of the B vitamins. The ileum, the last stretch and the part Crohn's disease inflames most often, is the only site for vitamin B12 and the place bile acids are recycled; inflammation or a resection there makes both losses lasting. The colon reclaims water and potassium and absorbs the butyrate its bacteria make. Section J is organized around this drawing: which stretch is inflamed predicts what is missing, and what to test.

Never make changes to your protocol without consulting your gastroenterologist.

Section J · Vitamins & Minerals · food first, then the form

Food first, and why my score is a dash

The previous page drew where each nutrient crosses into you. This page is about how to think before you buy: nutrient-dense food first, a lab value before a bottle, and the forms that make a difference once a bottle is warranted.



EAT THE NUTRIENT FIRST

Liver, red meat, clams and broth for iron and B12; leafy greens and lentils for folate; nuts, seeds and pumpkin seeds for magnesium and zinc; fatty fish and egg yolk for vitamin D; fermented and leafy foods for vitamin K. A nutrient-dense diet corrects most mild shortfalls on its own, and the food comes with the cofactors the capsule leaves out.

TEST, THEN DECIDE WITH YOUR TEAM

Ferritin and a blood count for iron, serum B12 with methylmalonic acid if the value is borderline, 25-hydroxyvitamin D, and red-cell or serum folate and zinc where symptoms suggest them. A number tells you whether repletion is needed and lets you see it work; a guess does neither. Never take iron without a ferritin.

WHERE THE ANATOMY MATTERS.

Crohn's most often inflames the ileum, so B12, bile acids and the fat-soluble vitamins are the first casualties, and a resection there makes the loss permanent. Ulcerative colitis lives in the colon, where water, potassium and the bacterial short-chain fatty acids are lost. The map on the previous page shows the rest.

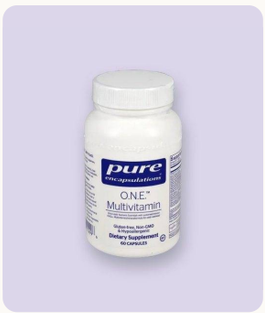
Why I do not score every vitamin

A score in this guide is my judgment of what a supplement does for IBD. A vitamin you are deficient in does not need my judgment; it needs a lab value, and the score would be a 5 for one person and irrelevant for the next. So the individual vitamins and minerals carry evidence bars and a dash for my score, which means "no personal opinion applies here," not a zero. The multivitamin (J-00) carries the one score in the section, a 4: repletion insurance, taken every second or third day so it does not overdo the B12 or the fat-soluble vitamins.

The forms that matter here

B6 as pyridoxal-5-phosphate (P5P) rather than ordinary pyridoxine hydrochloride, a view I generally share with the practitioners who advise it; the O.N.E. multivitamin's label, checked for this edition, gives 4 mg of B6 with 38% of it as P5P and the rest as pyridoxine HCl, so it partly meets that preference, and the standalone P5P 50 (J-14) exists for people who want the active form alone; a form preference is not a reason to take more of it. Folate as methylfolate. B12 as methylcobalamin, in the amount your team and your absorption dictate. Iron as a bisglycinate chelate, never ferrous sulfate in a sore gut. Magnesium as glycinate, the form least likely to loosen stool. (ref 208)

Section J · Vitamins & Minerals · highlighted products



J-00 · #—

The multivitamin

Pure Encapsulations, O.N.E. Multivitamin · 60 caps

Inflammation

One capsule covers the thirteen essential vitamins plus zinc, selenium, iodine, manganese, choline, CoQ10 and alpha-lipoic acid, which means it overlaps with vitamin D (A-05), CoQ10 (C-13), ALA (C-12), and most of the individual entries below. This is the first row on your tracking sheet, and the reason the sheet exists.

Contains 2,000 IU vitamin D, add that to your total before adding the Jarrow D3.

Reference 161

Andrew's notes

I take this every second or third day rather than daily, and I would consider that for most men. Part of the reason is the fat-soluble vitamins; part is B12, where one large observational study found that men who took high-dose B12 from individual supplements for years, not from a multivitamin, had more lung cancer, most strongly if they smoked, with no such signal in women. That is an association, not proof of cause, and it is not a reason for men to avoid B12; if you have had a terminal ileal resection or a documented deficiency, replacing B12 matters far more than this caution, and food sources (meat, fish, eggs) count. Discuss the schedule with your gastroenterologist, GP or integrative practitioner. (ref 204)

Buy on Fullscript →

go.supplementsforibd.com/multivitamin

SKU PUR-ONE6

Evidence —

Repletion entry, guided by a lab test, not by trials.

Andrew's score 4

Andrew's judgment, 1–5.





Lentils and spinach

J-01 · #79

Iron

Thorne, Iron Bisglycinate NSF · 60 caps

Replenish

Iron deficiency is the most common deficiency in IBD; European guidelines call for a blood count, ferritin and CRP every three months in active disease and every six to twelve in remission, and they make intravenous iron the first choice when disease is active, oral iron isn't tolerated, or hemoglobin is below 10. Standard ferrous sulfate is exactly what a sore gut can't tolerate. Three gentle, well-absorbed options here: a bisglycinate chelate, a glycinate-plus-vitamin-C capsule, and a micronized liquid you can titrate.

Never supplement iron without a ferritin test, too much is as harmful as too little. Oral iron feeds some bad bacteria; in active disease, IV iron is often the right call.

References 135–137

Andrew's notes

I'm always a bigger fan of getting iron from food, but sometimes a supplement is really needed, and it can dramatically help people who have been depleted feel better. Iron may lean slightly inflammatory, but the benefit of having energy again usually outweighs any change in stool color or inflammation. Food sources: animal protein, bone broth, clams, and a few vegetables.

Buy on Fullscript →

go.supplementsforibd.com/iron

SKU THO-M226

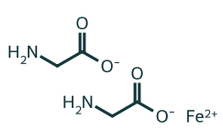
Also Pure Encapsulations Iron-C, go.supplementsforibd.com/iron-c
Pure Encapsulations Iron Liquid, go.supplementsforibd.com/iron-liquid

Evidence —

Repletion entry, guided by a lab test, not by trials.

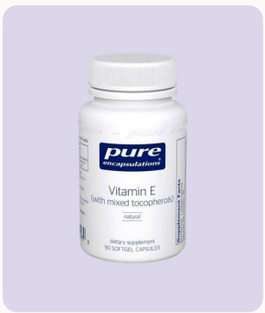
Andrew's score 4

Andrew's judgment, 1–5.



Iron bisglycinate · $C_4H_8FeN_2O_4$ · 204 g/mol · PubChem CID 9837124

Section J · Vitamins & Minerals · highlighted products, continued



J-13 · #91

Vitamin E

Pure Encapsulations, Vitamin E (mixed tocopherols) · 90 softgels

Replenish · Inflammation

Natural d-alpha tocopherol (400 IU, 260 mg) with 67 mg of the other tocopherols, the family of forms found in food, rather than a single synthetic form; in rapeseed and sunflower oil in a gelatin softgel, label checked September 2026. The IBD evidence is small and rectal: an Iranian open-label pilot gave vitamin E enemas (8,000 IU a day for 12 weeks) to 15 people with active UC and reported the Mayo score falling from 8 to 2.3 with remission in 64%. That is evidence about an enema, not about swallowing a capsule, and this card does not pretend otherwise; the oral rationale is antioxidant support and repletion in people who absorb fat poorly, which in IBD is common.

Fat-soluble, so total intake adds up across products. High doses add to the effect of anticoagulants and antiplatelet drugs; stop before surgery. Capsule contents are not formulated for the skin.

Reference 152

Andrew's notes

I hold vitamin E in high regard as an antioxidant, and I like this product: mixed tocopherols, the family of forms found in food, rather than a single synthetic one. For people with Crohn's who absorb fat poorly it is one of the nutrients most quietly short, and I have seen skin, energy and recovery improve when it is replaced. Whether you need it is still a question for a lab value and your absorption; my 4 is for the product and the rationale, not a reason to take it blind.

Buy on Fullscript →

go.supplementsforibd.com/vitamin-e

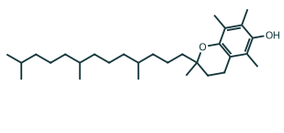
SKU PUR-DE9

Evidence 3

Small open-label enema pilot in UC; oral evidence adjacent

Andrew's score 4

Andrew's judgment, 1–5.



Alpha-tocopherol, vitamin E · $C_{29}H_{50}O_2$ · 430.7 g/mol · PubChem CID 14985

Iron, three ways (J-01): which form for whom

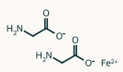
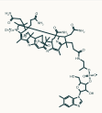
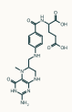
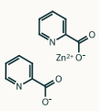
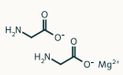
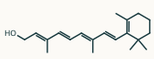
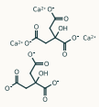
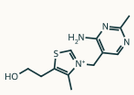
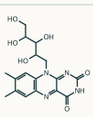
Product	Pros	Cons	Link
Thorne Iron Bisglycinate · 25 mg capsule	Chelated, gentle on the gut, well absorbed; one small capsule, NSF certified.	Fixed dose; no vitamin C in the capsule.	go.supplementsforibd.com/iron
Pure Encapsulations Iron-C · capsule	Glycinate iron with vitamin C in the same capsule, which improves absorption.	Fixed dose; the added vitamin C is plain ascorbate.	go.supplementsforibd.com/iron-c
Pure Encapsulations Iron Liquid · 120 mL	Micronized liquid you can measure out, so the dose can start low and rise; easy when swallowing capsules is hard.	Taste; a bottle to keep track of; still oral iron, with the same rule about ferritin first.	go.supplementsforibd.com/iron-liquid

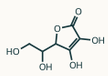
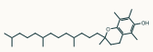
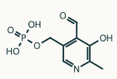
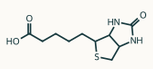
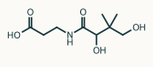
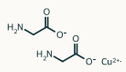
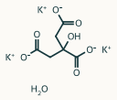
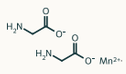
Oral iron is for mild deficiency in quiet disease, with a ferritin test before and after. In active disease, when oral iron is not tolerated, or when hemoglobin is low, intravenous iron through your gastroenterologist is often the right call; that is the guideline position, not mine alone. Products re-checked September 2026.

Section J · Vitamins & Minerals

All 22 entries, with links

★ = highlighted above with a full product card. Evidence bars use the 1–5 scale from "How to read this guide"; Andrew's rating is his own judgment, given for the highlighted entries. All links route to Andrew's Fullscript dispensary (US shipping only). "No product" = no clean single-ingredient option existed on Fullscript at press time.

#	ID	Entry	Structure	Evidence / Andrew	Product · link	What to know
79	J-01	★ **Iron** ● Replenish		Evidence — Andrew ■■■■□ 4	Thorne Iron Bisglycinate NSF; Pure Encapsulations Iron-C; Pure Encapsulations Iron Liquid go.supplementsforibd.com/iron go.supplementsforibd.com/iron-c go.supplementsforibd.com/iron-liquid	Most common deficiency in IBD References 135–137
80	J-02	**Vitamin B12** ● Replenish		Evidence ■■■□□ 3 Andrew —	Pure Encapsulations B12 Liquid (methylcobalamin) go.supplementsforibd.com/b12	Absorbed only in the terminal ileum, so ileal Crohn's and resection make deficiency likely. A Dutch RCT found extra B12 does not relieve fatigue in people who aren't deficient, so test first. Liquid methylcobalamin bypasses the digestive problem. Reference 138
81	J-03	**Folate (B9)** ● Replenish		Evidence ■■■□□ 3 Andrew —	Thorne 5-MTHF 1 mg go.supplementsforibd.com/folate	Sulfasalazine and methotrexate both deplete folate; 5-MTHF is the active form. Safe alongside methotrexate for IBD. Reference 139
82	J-04	**Zinc** ● Replenish		Evidence ■■■□□ 3 Andrew —	Pure Encapsulations Zinc 30 (picolinate) go.supplementsforibd.com/zinc	Lost in diarrhea; a Chicago cohort found zinc-deficient IBD patients had more hospitalizations, surgeries and complications, and that correcting zinc improved those outcomes. A 2025 series found 46% of patients deficient. Picolinate is a well-absorbed form. References 140–141
83	J-05	**Magnesium** ● Replenish		Evidence ■■■□□ 3 Andrew —	Pure Encapsulations Magnesium (glycinate) 120 mg go.supplementsforibd.com/magnesium	Lost in diarrhea and needed to activate vitamin D. Glycinate is the form least likely to loosen stool. Reference 142
84	J-06	**Vitamin A** ● Replenish		Evidence ■■□□□ 2 Andrew —	Pure Encapsulations Vitamin A 10,000 IU go.supplementsforibd.com/vitamin-a	Supports mucosal immunity and epithelial differentiation. Fat-soluble; watch total intake with the multivitamin. Reference 143
85	J-07	**Calcium** ● Replenish		Evidence ■■■□□ 3 Andrew —	Pure Encapsulations Calcium (Citrate) go.supplementsforibd.com/calcium	Bone loss is a common IBD complication, worsened by steroids. Citrate absorbs without stomach acid. Reference 144
86	J-08	**Thiamine (B1)** ● Replenish		Evidence ■■■■□ 4 Andrew —	no product —	A Danish crossover RCT (n = 40) found four weeks of high-dose thiamine (600–1,800 mg/day, by weight and sex) cut fatigue scores by 4.5 points versus none on placebo in quiescent IBD; 300 mg/day did not hold the gain. In the multivitamin; the high doses need guidance. References 145–147
87	J-09	**Riboflavin (B2)** ● Replenish		Evidence ■■■□□ 3 Andrew —	no product —	The Dutch RISE-UP study gave riboflavin to Crohn's patients and reported microbiome and oxidative-stress changes. In the multivitamin. Reference 148

88	J-10	**Niacin (B3)** ● Replenish		Evidence 1 Andrew –	no product —	Signals through GPR109A, the same receptor as butyrate, in colonic epithelium. In the multivitamin. Reference 149
89	J-11	**Selenium** ● Replenish		Evidence 2 Andrew –	Pure Encapsulations Selenium (selenomethionine) go.supplementsforibd.com/selenium	Cofactor for glutathione peroxidase; often low in IBD. Reference 150
90	J-12	**Vitamin C** ● Replenish		Evidence 2 Andrew –	PERQUE Potent C Guard Powder (buffered ascorbates); PERQUE Potent C Guard 1000 mg Tabsules; Pure Encapsulations Buffered Ascorbic Acid Powder; Flora Organic Acerola Powder (whole-food vitamin C) go.supplementsforibd.com/potent-c-guard go.supplementsforibd.com/potent-c-guard-tablets go.supplementsforibd.com/vitamin-c go.supplementsforibd.com/acerola	Buffered ascorbate powder with no other ingredients; the mineral load also helps constipation, and plain ascorbic acid loosens stool. Four options: PERQUE's buffered powder (1,584 mg per half-teaspoon) and 1,000 mg Tabsules, the Pure Encapsulations powder, and a whole-food acerola powder (850 mg per 3 g scoop) for people who want vitamin C from a fruit. The exercise note in Section F explains why I take it before training. Reference 151
91	J-13	**★ Vitamin E** ● Replenish		Evidence 3 Andrew 4	Pure Encapsulations Vitamin E (mixed tocopherols) go.supplementsforibd.com/vitamin-e	An Iranian open-label pilot of vitamin E enemas (8,000 U/day, 12 weeks) in 15 people with active UC dropped the Mayo score from 8 to 2.3 with remission in 64%. Rectal, not oral. Mixed tocopherols are the form the body recognizes. Reference 152
92	J-14	**Vitamin B6** ● Replenish		Evidence 2 Andrew –	Pure Encapsulations P5P 50 (B6) go.supplementsforibd.com/b6	Low in IBD and lowered further by inflammation. P5P is the active form. Reference 153
93	J-15	**Vitamin K2** ● Replenish		Evidence 2 Andrew –	Jarrow Formulas MK-7 90 mcg (vitamin K2) go.supplementsforibd.com/vitamin-k2	Vitamin K deficiency is documented in Crohn's; K2 directs calcium to bone. Standalone MK-7; warfarin interaction. Reference 154
94	J-16	**Biotin (B7)** ● Replenish		Evidence 1 Andrew –	no product —	Biotin transport is altered in experimental colitis. In the multivitamin.
95	J-17	**Pantothenic acid (B5)** ● Replenish		Evidence 1 Andrew –	no product —	Wound-healing roles; in the multivitamin.
96	J-18	**Choline** ● Replenish		Evidence 1 Andrew –	no product —	Direct precursor to phosphatidylcholine (F-08). In the multivitamin.
97	J-19	**Copper** ● Replenish		Evidence 1 Andrew –	no product —	Cofactor for SOD1; long-term zinc without copper depletes it. In the multivitamin.
98	J-20	**Potassium** ● Replenish		Evidence 1 Andrew –	no product —	Lost in diarrhea; food first (bananas, potatoes, broth). Standalone capsules are capped at 99 mg and not worth linking.
99	J-21	**Iodine** ● Replenish		Evidence 1 Andrew –	no product —	Thyroid function; in the multivitamin.
100	J-22	**Manganese** ● Replenish		Evidence 1 Andrew –	no product —	Cofactor for mitochondrial SOD2; in the multivitamin.



K

SECTION K · REFERENCE · FOUR PAGES

Buying Well

The label matters as much as the ingredient, and most people never read past the front of it. This section is about the rest of the bottle: what the additive lists are hiding, why magnesium stearate shows up on three labels for one product and whether it matters, which excipients I treat as tiebreakers and which I refuse outright, how I vet a brand before it earns a place in this guide, and why bioavailability, the form the molecule arrives in, so often decides whether a dose does anything at all. It closes with exactly how to order through my dispensary, why the links exist, and what to do if you live outside the United States.

Illustration: an amber bottle with a blank label, a brass scale and a magnifying glass

Never make changes to your protocol without consulting your gastroenterologist.

Section K · Buying Well

What else is in the capsule

Additives, binders and flow agents, the half of the label most guides ignore, and the reason two products with the same active ingredient are not the same product.



Five to avoid

Additives with published evidence of harm to the gut barrier or microbiome in experimental models, and, in a few cases, in small human studies. The evidence is not all of one kind: the emulsifiers CMC and polysorbate 80 have the deepest record, from mouse colitis through a controlled feeding trial in people; carrageenan has animal data and one tiny UC relapse study; maltodextrin and titanium dioxide rest on laboratory and animal work. None of this proves that a capsule with a few milligrams harms a particular person. IBD is simply the condition in which I would rather not run that experiment on myself, and a product without them is usually available.

Additive	Why it's on the list
Carboxymethylcellulose (CMC)	Emulsifier. Thinned the mucus layer, altered the microbiome and promoted colitis in mouse models; a controlled human feeding study found microbiome and metabolite changes.
Carrageenan	Seaweed-derived thickener. Used experimentally to *induce* colitis in animals; a small pilot in UC patients in remission found earlier relapse with continued exposure.
Maltodextrin	Filler and sweetener. Promotes adherent-invasive *E. coli* biofilm and impairs mucus in models; common in powders.
Titanium dioxide	Whitening pigment in tablets and capsules. Nanoparticles accumulate in gut immune cells and worsen experimental colitis; banned as a food additive in the EU.
Polysorbate 80	Emulsifier. Increased bacterial translocation across the epithelium in models; the same colitis-promoting pattern as CMC.

Sources: the Chassaing emulsifier series (mouse colitis 2015, human microbiota ex vivo 2017, a randomized controlled-feeding study in people 2022), the M-cell translocation work on polysorbate-80, and the titanium dioxide, maltodextrin and carrageenan studies listed in the references (refs 162–172). Note that **carboxymethylcellulose** is not the plain cellulose or hydroxypropyl methylcellulose of most vegetable capsules, which are not on this list.

The magnesium stearate note

Magnesium stearate is probably the most common additive in supplements, a flow agent that keeps powder from sticking to machinery. Unlike the five above, there is little to no evidence that it causes harm, and like everything else, its specific effect in IBD is unknown. My view: probably safe if it's in one or two of your products; less certain when it's in all fifteen and you are taking a meaningful quantity every day. So I treat it as a tiebreaker. When two products are otherwise equivalent, I pick the one without it.

One ingredient, three labels

Theracurmin, the engineered curcumin used in the Crohn's RCT, is a branded ingredient licensed to three manufacturers. **Integrative Therapeutics'** version contains no magnesium stearate; **Natural Factors'** and **Bioclinic Naturals'** versions both do. Same active ingredient, same trial behind it, three different additive profiles. That is why every product card in this guide prints the excipients, including the flow agents in the Thorne phytosome chosen for A-01, and why "just buy any curcumin" is bad advice.

Excipients that aren't the enemy

Not every inactive ingredient is a problem. Cellulose capsules, microcrystalline cellulose, rice flour, ascorbyl palmitate, and the delivery-system components of engineered forms, gum ghatti in Theracurmin, phospholipids in a phytosome, the SNAC enhancer in an oral peptide, are doing a job; in the engineered forms they *are* why the product works. The question is not "is there anything besides the active ingredient?" but "is each thing here for a reason I understand?" Sometimes the answer is a trade: Theracurmin HP carries maltodextrin, on the list above, inside the form that ran the only Crohn's trial. I print that rather than hide it.

Section K · Buying Well

How to vet a brand, and why the form matters

Seven questions to ask about any brand

I choose products one at a time, not brands wholesale. A company can make one product I trust and another I advise against, and my recommendation of the first is not a recommendation of the second. Companies get bought, and formulas change quietly after an acquisition, so I keep checking labels and I want to hear when a product disappoints you: help@supplementsforibd.com. If you prefer another well-tested brand of the same ingredient, that is a reasonable choice; the newest edition of this guide is the one to trust.

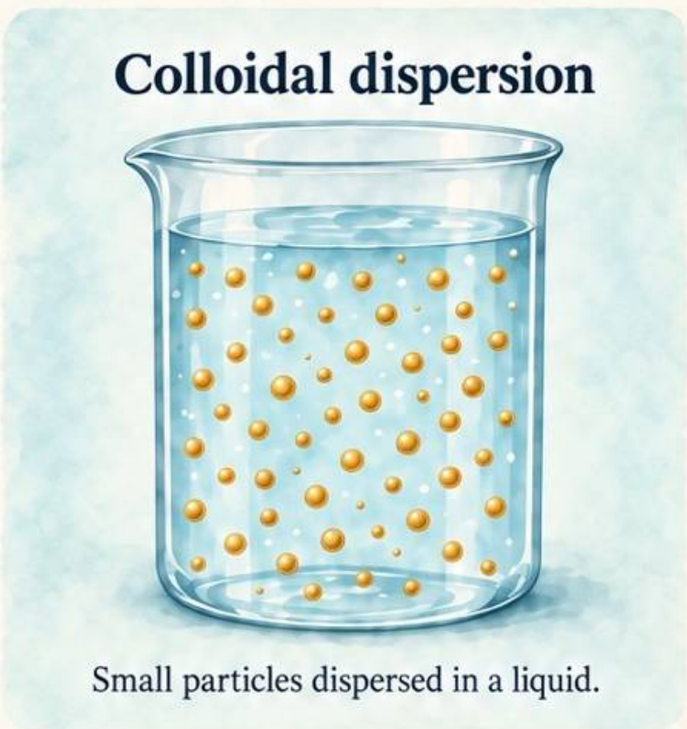
1. **How long has the brand been around?** Longevity isn't quality, but a brand that has survived a decade of recalls has usually learned something.
2. **Does the company answer email?** Ask for a certificate of analysis for a specific lot, including the contaminant panel: heavy metals, microbes, solvents. The speed and quality of the answer tells you most of what you need to know.
3. **Who owns it?** Your favorite brand is probably owned by a very large corporation. Not disqualifying, but ownership changes tend to precede formulation changes, which is one reason I re-check every product at each edition.
4. **Is it third-party tested, and is the testing published?** NSF, USP, Informed Choice, or a lab CoA you can read, not a logo that says "tested."
5. **What else is in it?** Run the label against the previous page. Every additive should have a reason.
6. **Is there an excess of active ingredients?** More is not better, and "proprietary blend" is a way of not telling you the dose of anything.
7. **What's the bioavailability story?** For curcumin, quercetin, glutathione, butyrate, CoQ10 and the peptides, the form decides whether the label dose means anything.

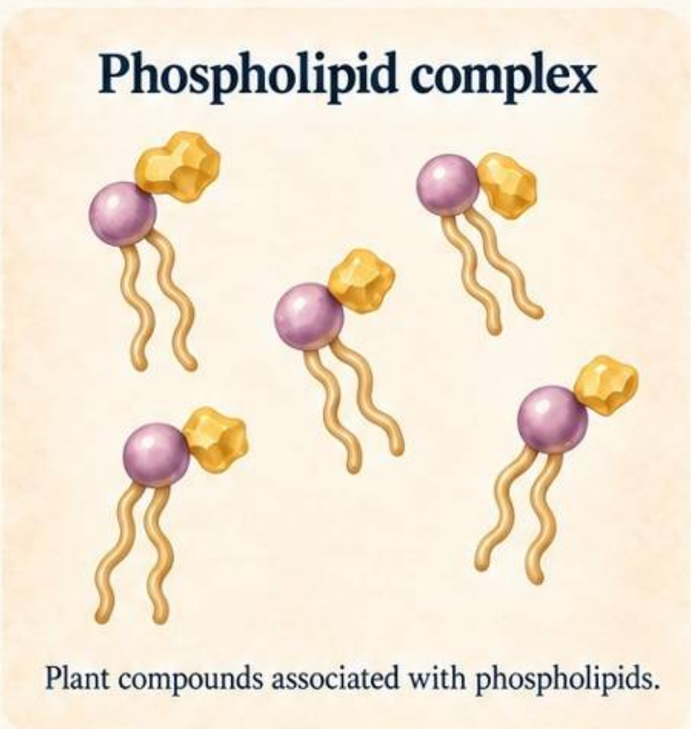
Bioavailability: the forms you'll see in this guide

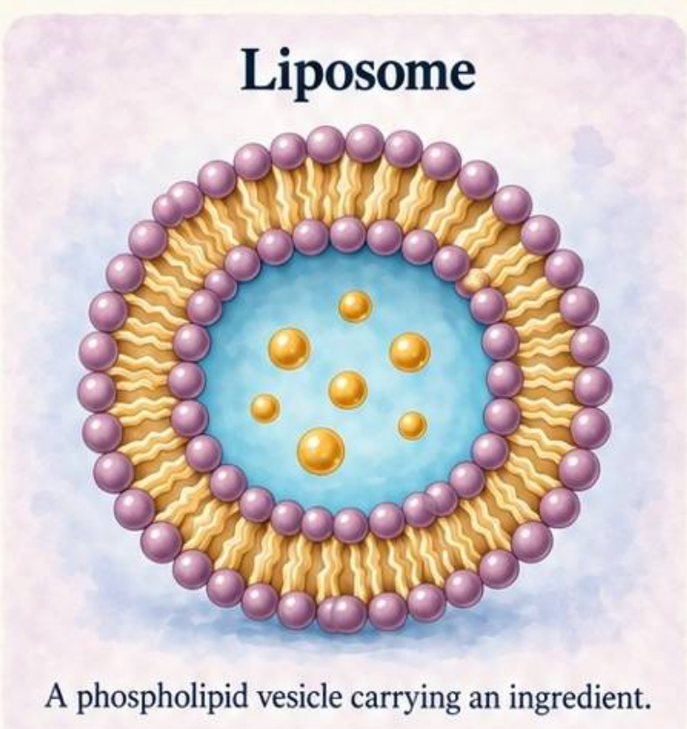
Form	What it does	Where it matters
Colloidal dispersion	Active milled to sub-micron particles, suspended with a gum so it stays dispersed in water. Theracurmin, the form in the Crohn's RCT.	Curcumin (trial form)
Phytosome	Plant compound bound to a phospholipid, which carries it across the gut wall. Meriva (the A-01 product), Casperome (C-02), Quercefit.	A-01 curcumin, C-02 boswellia
Liposomal	Active enclosed in a phospholipid bubble; protects fragile molecules from digestion. Quality varies.	C-11 glutathione, G-01/G-02 peptides
Enteric / targeted release	Coatings or matrices that delay release to the small intestine or lower gut. Essential for peppermint oil; used in the positive fish-oil trials; the whole problem for butyrate, otherwise absorbed before it reaches the colon.	H-01 peppermint, A-03 omega-3, F-02 butyrate
Triglyceride vs ethyl ester	Fish oil in its natural triglyceride form is absorbed better than the cheaper ethyl-ester concentrate, especially without a fatty meal.	A-03 omega-3
SNAC	Salcaprozate sodium, an absorption enhancer for oral peptides (the carrier in oral semaglutide). Used in some BPC-157 capsules; the liposomal liquid matched here takes a different route.	G-01 BPC-157

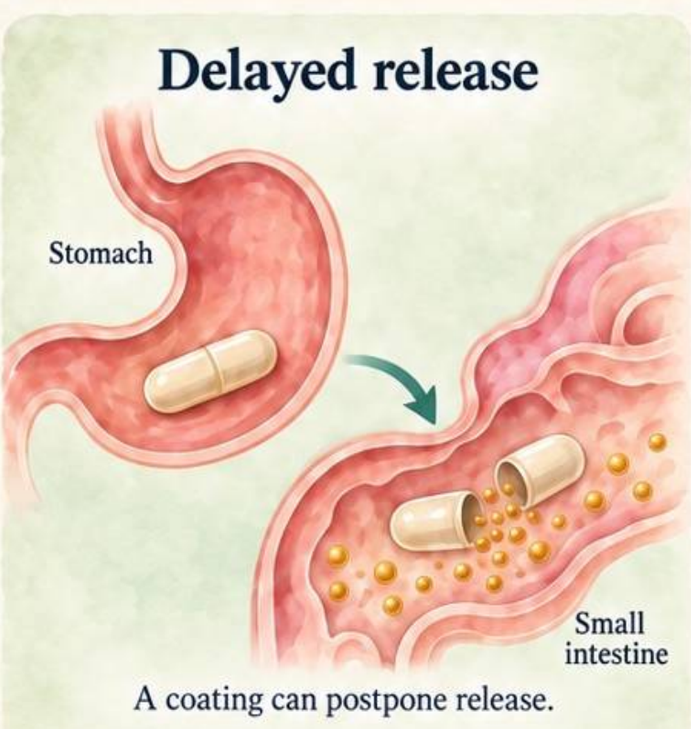
A caveat on coatings. Coatings are additives too, and can irritate some people with IBD. If a coated product causes new symptoms and the uncoated one doesn't, believe your gut.

Why formulation matters









Delivery forms do different jobs. A colloidal dispersion mills an ingredient into very small particles kept suspended in liquid; Theracurmin, the curcumin in the Crohn's trial, is built this way. A phospholipid complex, sold as a phytosome, binds a plant compound to a phospholipid that carries it across the gut wall, as in Meriva curcumin and Casperome boswellia. A liposome encloses the ingredient in a phospholipid vesicle to protect it from digestion, as in the glutathione and peptide liquids. A delayed-release coating changes where a capsule opens: the whole point for peppermint oil, the whole problem for butyrate. None of this makes products interchangeable: ingredient, target, form and trial have to match, and for an ingredient meant to act inside the gut, more of it in the blood is not the goal.

Never make changes to your protocol without consulting your gastroenterologist.

Section K · Buying Well

How to buy, the dispensary

Almost every product in this guide is available through my Fullscript dispensary; the few that are not say so on their pages. Here is what the dispensary is, how it works, why I trust it, and what happens to your money.

What Fullscript is

Fullscript is a practitioner supplement platform: a catalog of professional-grade brands that ships direct from the manufacturer's supply chain rather than through third-party marketplace sellers, so what you receive is what the label says, stored the way it should be. Practitioners open a dispensary on it and recommend products to the people they work with. Mine is the one every link in this guide points to.

How the links work

Every product card carries a short link of the form go.supplementsforibd.com/<product>. It opens that exact product in my dispensary. You browse without an account; you create one at checkout, name, email, shipping address. Orders ship from Fullscript. Once you have an account through my dispensary, future orders and refills are attributed to it too, which is how this free guide funds its own next edition.

> **The dispensary link**
>
> go.supplementsforibd.com/dispensary
>
> The whole storefront, organized in the same sections as this guide. Every per-product link routes to the same dispensary.

Why I trust Fullscript

I have used Fullscript for years, for myself and with the people I work with, and I trust it for practical reasons rather than promotional ones. It carries practitioner-grade brands and ships from a supply chain it controls, so the bottle that arrives is the product the label describes, stored as the manufacturer intended. Its catalog pages print the full supplement facts and other ingredients, which is what made the label checks in this guide possible. I am grateful to it for making a free guide fundable, and I say that as someone it pays a commission.

Where it ships

My dispensary ships within the **United States only**: Fullscript requires practitioner and customer to be in the same country, and mine is US-based. No international shipping and no freight forwarders through the platform. Outside the US, the evidence is yours, the links are not; the email invitation opposite is the route to try.

What I earn

I earn a commission on every order placed through my dispensary. That's the plain version of the disclosure on page 1, repeated here because this is the page where you'd actually spend money. It does not change what you pay relative to buying the same product elsewhere on the platform. It does mean I have a financial interest in you buying something, and you should weigh my highlights knowing that.

Outside the US, or have a question?

If you live outside the US and want help getting hold of a supplement, email us and we will do what we can. It usually takes longer and costs more, and not every product can be shipped to every country, but we will try to find you a route. Same address for any question: **help@supplementsforibd.com**.

If you already have a Fullscript account

Many people with IBD already have a Fullscript account through another practitioner. If you do, I ask that you kindly order through the links in this guide anyway; that supports this work.

Prices

Not printed here; they change, and the platform keeps them on the storefront.

> **You don't have to buy anything**
>
> Every product in this guide is described by brand, name and SKU so you can find it anywhere you like; the few products not on Fullscript are named where they appear. The links are how you support the work if you want to. The information is free either way, and so is the newest version, at supplementsforibd.com.



L

SECTION L · REFERENCE · FIVE PAGES

Beyond the Hundred

What did not make the list, and why. A hundred is a round number and an honest one: I could have padded the guide to a hundred and fifty with things that have a mechanism and no evidence, and I chose not to. This section holds the rest of the conversation, and I mean conversation: several of the things here are ones I am actively exploring, and a few are companies I would like to build a relationship with. Thirteen honorable mentions worth knowing about, including the two I am watching most closely, indigo naturalis and a high-potency multi-strain probiotic with real trials, and exactly why each stays here for now. A note on enemas and the Briggs Protocol, the one approach in these pages that comes from a first-principles reading of the disease rather than a bottle. The cannabis page, because it is the most-asked-about item in the IBD community and deserves more than a paragraph, and now has a drawing of the system it acts on. And the table of things people ask about constantly that I considered and excluded, with the reason in each case. A large collection narrowed to a curated few is how you know the hundred were chosen carefully; this is where the narrowing shows.

IN THIS SECTION

Honorable mentions 92 Enemas and the Briggs Protocol 92 Asked about, didn't make the cut 94
Cannabis, THC and CBD 96 The endocannabinoid system, drawn 97

Illustration: apothecary jars, a large collection and a curated few

Never make changes to your protocol without consulting your gastroenterologist.

Section L · Additional to the 100

Honorable mentions

Thirteen things with strong evidence or enormous interest that I am still exploring, and nothing to link yet, because they are not sold in the US, are not supplements, or are not on the dispensary. Some are investigational, some are unsuitable, and some are simply not available to me yet; the reason is printed in each case. This section is a credibility asset, not an apology.

Cannabis, THC, CBD, CBG

The most-asked-about item in the IBD community, and the reason it has a full page and a drawing of its own at the end of this section. The endocannabinoid system runs through the gut's nerves, its immune cells and its lining, and cannabis reaches all three: CB1 on the enteric nerves slows spasm and pain, CB2 on immune cells quiets TNF-α and IL-1β, and in models the barrier tightens. The randomized trials show reliable relief, better sleep and better quality of life, and have not yet answered whether the inflammation itself changes, which is a question your gastroenterologist still has to check with a scope. Not on Fullscript (dispensary-only where legal), and a conversation to have openly with your team, who have had it many times before. The full page is where the detail lives.

E. coli Nissle 1917 (Mutaflor)

A probiotic strain with randomized trials showing equivalence to mesalamine for maintaining UC remission, the best-evidenced single-strain probiotic in the disease. Not available in the United States: the product was withdrawn from the US market when the FDA classed it as a biologic drug rather than a supplement, and it has not returned. If you have access to it abroad, the trial dose was two capsules a day, taken for a year, in remission; it is a maintenance tool, not a rescue.

Exclusive enteral nutrition

Complete liquid formula diets (Modulen IBD and similar) used as the sole source of nutrition for six to eight weeks. The best-evidenced non-drug way to induce remission in pediatric Crohn's disease, with mucosal healing rates comparable to steroids and better than them on several endpoints, and the reason European pediatric guidelines list it as first-line induction therapy. It works, as far as anyone can tell, by removing the food antigens and emulsifiers the microbiome reacts to and by resting the wall, which is a diet argument made at full volume. Adults tolerate it less well, and partial versions (half the calories as formula) are under study. Not a supplement, a medical nutrition therapy done with a dietitian, and the proof of concept for everything the diet page in this guide says.

Fecal microbiota transplantation (ref 159)

Multiple positive randomized trials in ulcerative colitis, with remission rates well above placebo when donor material is intensive and pooled: the Australian trial that used stool from several donors, given five days a week for eight weeks, roughly tripled remission against placebo, and the Canadian trial found that one donor's stool worked and another's did not, which is the whole difficulty in a sentence. In Crohn's the results are thinner and less consistent. A procedure, not a product, still investigational for IBD, and the reason I take the microbiome seriously enough to give it two sections.

Butyrate enemas

Rectal sodium butyrate has better UC data than oral butyrate for the simple reason that it reaches the target tissue: the small Italian and German trials used 60 to 100 mL enemas of 80 to 100 mmol/L butyrate, alone or alongside mesalazine, in distal colitis, with improvement in bleeding, endoscopic scores and histology in most of them. Requires a compounding pharmacy and a prescription, and the enema note below is where I say what I think about the method.

Germinated barley foodstuff

A prebiotic fiber preparation with a series of positive Japanese UC trials for both induction and maintenance. No US product.

Delayed-release phosphatidylcholine (LT-02)

Three positive UC trials on a specific delayed-release formulation developed as a drug, and never commercialized. The phosphatidylcholine products you can buy (entry F-08) are not the same formulation, and the trial results should not be read as applying to them.

Indigo naturalis (Qing Dai)

Among the strongest botanical randomized-trial results in UC: a Japanese trial found dose-dependent clinical response, with remission in a majority at the higher doses over eight weeks, in people who had failed conventional therapy. The active molecules, indirubin and indigo, act on the aryl hydrocarbon receptor, the same switch the tryptophan metabolites of Section I use to tell the wall to repair itself. It also carries real safety signals: pulmonary

arterial hypertension and intussusception have been reported, and the trial itself was stopped early on the first of them. Not on Fullscript as of this edition; it is available through traditional Chinese medicine channels and, under supervision, through the program described next, and it is not something to source casually.

The one non-Fullscript product in this guide. Evinature's CurQD protocol pairs curcumin with Qing Dai in a program supervised by gastroenterologists, and it is the only way I know to use Qing Dai responsibly. Dr. David T. Rubin, chief of gastroenterology at the University of Chicago, sits on Evinature's advisory board (evinature.com/pages/advisory-board). He is an extraordinarily compassionate gastroenterologist, someone I have met personally, and someone with an open mind, and that is one reason I would support this product even though it is not on Fullscript. If Qing Dai interests you, start there and with your GI, not with a bag of powder.

Tripterygium wilfordii (thunder god vine)

Post-operative Crohn's recurrence data rivaling mesalamine, alongside hepatotoxicity and infertility signals. An explicit **do-not-source** entry: it is here so you recognize it, not so you find it.

Xilei san

A Chinese herbal enema formula with randomized-trial data in pouchitis and distal UC. No Western product.

Trichuris suis ova (helminth therapy)

Pig whipworm eggs, genuinely tested in randomized IBD trials on the hypothesis that the immune system evolved expecting parasites. Early open-label results were striking; the large phase 2 trials in Crohn's were negative. The story is too good to omit.

Larazotide acetate

A tight-junction regulator that reached phase 3 in celiac disease before the program was halted. An investigational drug with no supplement form, included because it is the clearest example of "barrier repair" being pursued as pharmacology.

Faecalibacterium prausnitzii

The most consistently depleted organism in Crohn's disease, and one of the most anti-inflammatory bacteria known. Now purchasable inside next-generation commensal products, a multi-strain product combining *F. prausnitzii*, *Roseburia* and *Akkermansia* exists on the dispensary, but there are zero intervention trials in IBD and the category is about two years old. High interest, unproven. The most likely first promotion into the main list in a future edition.

A note on IBD-branded products. There are several supplement brands marketed specifically for IBD right now. I am not highlighting them, because of the sheer volume of side effects I have seen with them. If you are considering one, discuss it with your gastroenterologist.

Promotion path: anything here that becomes buyable on Fullscript can move into the 100 in a later edition, taking the next unused ID in its section.

The watch list for the next edition

Five things I expect to move, in the order I expect them to move. A single-strain *F. prausnitzii* product with survival data and a trial. Visbiome, if it ever reaches Fullscript, because the pouchitis evidence is the best in its category. A CBD or full-spectrum product with a certificate of analysis I can print, once the hemp law settles. A human milk oligosaccharide (2'-FL) with an IBD trial rather than an IBS one. And indigo naturalis under supervision, if the safety monitoring in the Evinature program holds up over years rather than months. None of them is in the hundred today, and the reason is the same in every case: I would rather be a year late than wrong in print.

A note on enemas, and the Briggs Protocol

You will have noticed how often this guide says "rectal, not oral": butyrate, vitamin E, *L. reuteri*, colostrum, aloe. For disease in the rectum and left colon, delivering something directly to the tissue is the most reliable way to get it there, and a fair share of the best trial results in this guide were earned that way. I'll be honest about where I stand: I am not a fan of enemas, personally. Some people, however, have found them very helpful, and you deserve to know the option exists and to raise it with your gastroenterologist.

If you want to read the most thoughtful lay account of that approach, look up the **Briggs Protocol**: a long paper by **Dr. Michael Briggs**, a physicist, not a physician, who recovered from twelve years of ulcerative colitis and wrote up his reasoning with more than two hundred references. He uses specific supplements and herbs as retention enemas (vitamin E, glutathione, colostrum, phosphatidylcholine and glutamine among them) alongside a three-phase plan: induce remission, heal the gut wall, maintain the gut wall. His understanding of IBD, a leaky epithelial barrier, bacterial translocation and an over-reactive immune response, is very much in line with the loop in Section B. Read it critically, as he asks you to, and take it to your GI before you try anything in it. (refs 177–179)

Section L · Additional to the 100

Asked about, didn't make the cut

Twelve things people bring up constantly, what is claimed, what the evidence shows, and why each isn't in the guide.

Entry	What people claim	What the evidence shows	Why it's not in the guide
Tormentil (refs 157–158)	A European herb that calmed one small UC series completely	One open-label study of 16 UC patients: clinical index and CRP improved and reversed when it was stopped. A 2020 *Planta Medica* review: traditional use supported by lab and animal data; clinical studies insufficient.	No US practitioner product on Fullscript as of this edition; a European pharmacopoeia herb. If one appears with a clean label, it would be a candidate for a later edition.
Visbiome / VSL#3 (refs 155–156)	The probiotic with the best IBD evidence	True, multiple positive RCTs in UC and in pouchitis prevention and maintenance. Strain-specific, high-dose multi-strain formulation.	Sold direct by the manufacturer and through pharmacies; not on Fullscript as of this edition. I would welcome a relationship with the company; it would be in the 100 if I could link it. Visbiome and VSL#3 are now different products: the original formulation moved to Visbiome in 2016, and the cited studies used that formulation.
Thymosin alpha-1	An immune-modulating peptide that "resets" immunity	Real immunomodulatory evidence; approved as a drug in some countries. No IBD trials.	A prescription peptide (approved as a drug in some countries, not in the US), not a supplement, and not on Fullscript. I am interested in identifying a reputable, lawful source for people whose physicians prescribe it, which is a different thing from recommending it.
***Clostridium butyricum* MIYAIRI 588**	A butyrate-producing probiotic with clinical data	Japanese clinical data exist for this specific strain.	Strain not available in the US; generic *C. butyricum* appears only in multi-strain blends, not the studied product.
Human milk oligosaccharides (2'-FL)	The prebiotic in breast milk, for adults	Bifidogenic in small adult trials; IBS pilot data; no IBD trials.	Newer category with spotty practitioner distribution. Watch list.
Neem	Antimicrobial, anti-inflammatory Ayurvedic herb	Antimicrobial activity is real. Zero IBD evidence. Documented antifertility effects in both sexes; contraindicated in pregnancy and conception.	**Available on Fullscript, excluded on safety**, an IBD population skews young and female of childbearing age.
Oyster mushroom	One of the medicinal mushrooms	Some β-glucan and anti-inflammatory data, the weakest of the seven mushrooms considered. Widely eaten as a food across Asia and Europe, and one of the most cultivated mushrooms in the world.	Standalone products are uncommon; eat it as food. The other six mushrooms are in Section C.
Wheatgrass	Juice that heals UC	One small randomized UC trial (juice, 4 weeks) with improvement in rectal bleeding. Nothing since.	Weakest item considered for the anti-inflammatory section; a single small trial two decades old isn't enough for an entry, and I have not seen good effects with wheatgrass in my own work.
***Lactobacillus rhamnosus* GG**	The best-known probiotic strain	Excellent data in antibiotic-associated and infectious diarrhea. In IBD the trials are mostly negative, including a pediatric Crohn's maintenance trial.	Widely used, IBD data mostly negative. Popularity isn't evidence.
Grapefruit seed extract	A natural antimicrobial	Commercial products have repeatedly been found adulterated with synthetic preservatives (benzethonium chloride and others); the antimicrobial activity tracks the adulterant.	You cannot recommend a product whose active ingredient is the contaminant.
Black walnut	Anti-parasitic	No IBD evidence of any kind. Appears only in "parasite cleanse" blends.	Nothing to evaluate.
Mucin	Replace the mucus layer directly	The theory is sound, the mucus layer is genuinely dysfunctional in IBD. Evidence that swallowing mucin helps is not there; it is a large protein and is digested.	Good theory, no supplement evidence. The mucin *precursors* (NAG (F-06) and phosphatidylcholine (F-08)) are in the guide instead.

How the hundred were chosen

Four tests, in order. Is there a clean, single-ingredient product on Fullscript, or a food that makes a product unnecessary? Is there at least one human study in IBD, or a strong mechanism with human data in an adjacent condition, and an honest evidence bar to print beside it? Is the safety profile one I would accept for a client of mine, with the interactions and cautions known? And have I taken

What a "no" means here

Not that a thing is worthless. Visbiome has the best pouchitis evidence of any probiotic; I simply cannot link you to it. Neem is on Fullscript and works as an antimicrobial; I will not recommend a herb with documented antifertility effects to a population that skews young and female. Wheatgrass has one real trial, from 2002, and one trial is not

it, or watched it work or fail, in ten years in this community? Everything in the hundred passes the first three and most of it passes the fourth. Everything on this page fails at least one, and the right-hand column says which.

a shelf. A "no" here is a reason, printed, that you can disagree with. That is the standard I would want from anyone recommending me a bottle.

Brands I respect

Five companies doing something I think matters, none of them on my dispensary, named out of respect and an openness to future collaboration, not as an endorsement of everything they sell. **Evinature** (CurQD, curcumin with Qing Dai under gastroenterologist supervision; Dr. David T. Rubin, University of Chicago, sits on its advisory board). **Vinia** (whole red grape cells as a food-first source of the grape polyphenols behind C-06). **GIVOL** (the L-theanine spray I take; no spray exists on Fullscript, so M-03 links to a capsule). **Visbiome** (the best-evidenced high-potency probiotic in UC and pouchitis; sold direct, so it sits in the closing table). **Lineage Provisions** (Paul Saladino and Anthony Gustin's animal-based company, for taking nutrient-dense whole foods seriously; I have not evaluated a specific product, and a beef-organ complex is a candidate for a later edition, not one of the hundred). On CBD: I would name a company whose products carry a printable certificate of analysis and ship lawfully, and I have not found one since the hemp law changed. On peptide companies: interested, watching, not naming anyone yet.

Section L · Beyond the Hundred · the most-asked-about item in the IBD community

Cannabis, THC and CBD

The endocannabinoid system is everywhere in the gut: in its nerves, its immune cells and its lining. Cannabis acts on all three, and people with IBD reach for it more than for anything else in this section. This page is about using it honestly and well. The next page draws the system.

The system it acts on

Your gut runs its own cannabinoid chemistry. The enteric nervous system, the immune cells in the wall and the epithelium itself all carry **CB1** and **CB2** receptors, and the body makes its own ligands for them (anandamide and 2-AG). CB1 sits mostly on nerves and slows motility, secretion and pain signaling; CB2 sits mostly on immune cells and quiets inflammatory signaling, TNF-α and IL-1β among it. In animal colitis models cannabinoids lower inflammation and tighten the barrier, and in people with IBD the endocannabinoid system is measurably altered. None of that is controversial, and none of it is a matter of symptoms alone: these are levers on the nerves, on the immune cells and on the wall.

What the human trials show

In the randomized trials that exist, cannabis reliably improves pain, appetite, nausea, sleep and quality of life, and in the Israeli trials clinical disease-activity scores fell as well. What the trials have mostly not shown is a change in endoscopic scores or in calprotectin and CRP, in part because they were small and short and several did not scope. Read that as an open question rather than a verdict: the relief is real, and the proof of healing has not been gathered. Feeling better on cannabis is not evidence that the inflammation has gone, and in a disease where untreated inflammation is silently destructive, your team still needs to look. Observational data associate heavy use with more surgery in Crohn's, though cause and effect are unclear; smoking is a separate harm.

Strain and terpene profile matter

"Cannabis" is not one thing. The ratio of THC to CBD, the minor cannabinoids (CBG, CBN) and the terpenes (myrcene, limonene, beta-caryophyllene, which itself binds CB2) change what a product does. A high-THC product built for euphoria is a different tool from a balanced one built for spasm and appetite. If you use it, learn to read a certificate of analysis: total THC and CBD in milligrams, the terpene list, and the tests for pesticides, heavy metals and residual solvents. No lab data, no purchase.

This page is education; the decision belongs with you, your medical team and the law where you live. The system cannabis acts on is drawn on the next page.

Andrew's notes

I will be honest about my own experience. During a flare, cannabis has given me reliable relief from the tightness and spasm that nothing else touched, better sleep, and a calmer stress response, which this guide has spent a whole section arguing is not a small thing for an inflamed gut. I am also interested in cannabis as a tea, a traditional preparation with no standardized studied dose; that is an interest to declare, not a recommendation. The next day was often washed out, and I use it sparingly for that reason. I think it does more than manage symptoms, through CB2 on the immune cells and through the sleep and stress it repairs, and I also think the trials that would prove that have not been run. It sits alongside the medical plan, never instead of it.

The practical advice

1 Be honest with your gastroenterologist
Most have had this conversation many times. It changes how they read your symptoms and it belongs in your chart.

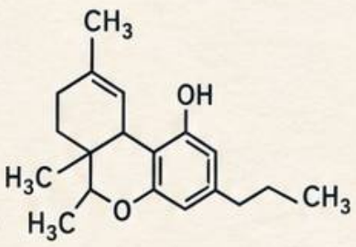
2 Comply with local law
Legality varies by state and country and changes often. Nothing here is a suggestion to break it.

3 Get lab data
Dispensary products with a certificate of analysis; nothing unlabeled, nothing from the informal market.

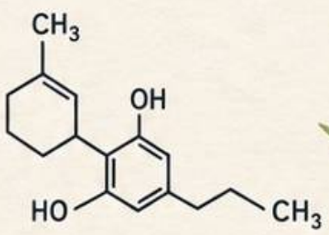
4 Start low, go slow
The smallest dose that helps, and a log of what it did. Edibles act late and last long; the second dose is where people get into trouble.

The endocannabinoid system in the gut



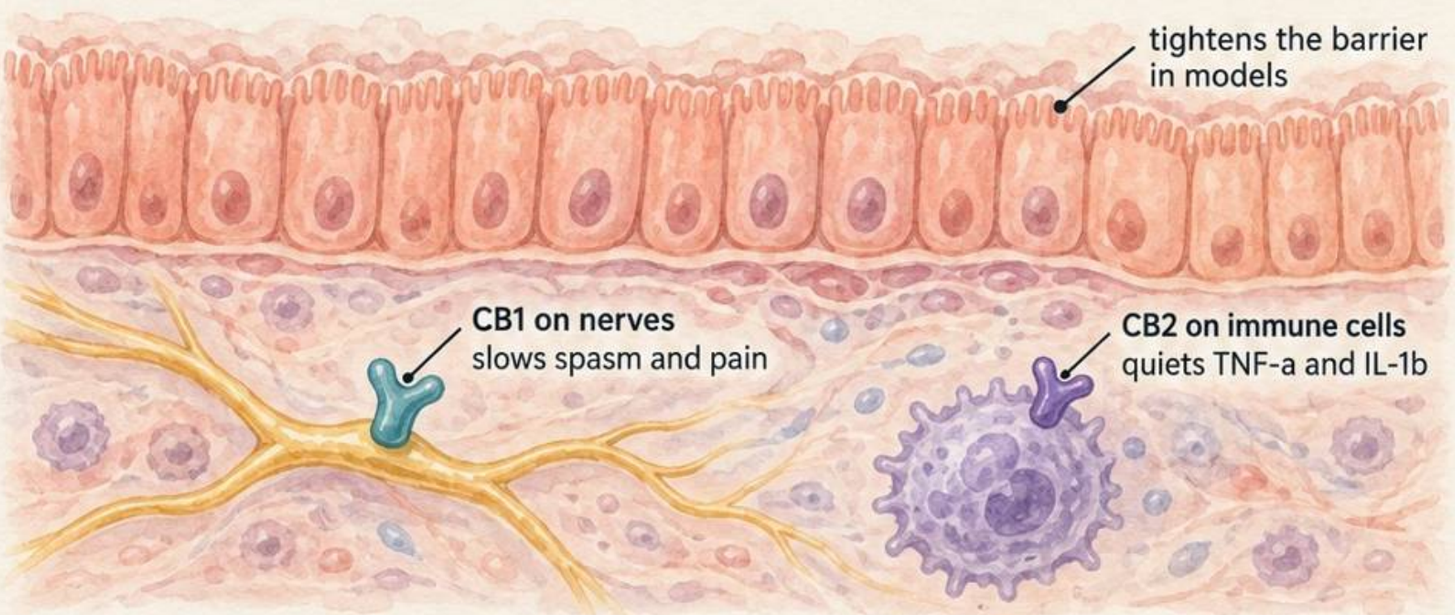


THC

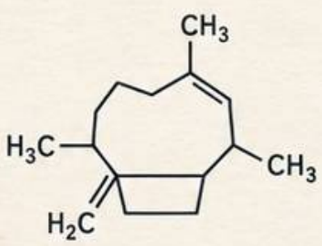


CBD









Beta-caryophyllene
a terpene that binds CB2



read the lab report

The gut runs its own cannabinoid chemistry, and cannabis borrows it. THC and CBD, drawn at the top, are the two molecules most people know. CB1 receptors sit on the enteric nerves, where activation slows spasm, motility and pain signaling; CB2 receptors sit on the immune cells in the wall, where activation quiets TNF-α and IL-1β. In laboratory and animal models, cannabinoids also tighten the epithelial barrier. Beta-caryophyllene, the terpene in black pepper and cloves, binds CB2 on its own, which is one reason a whole-plant preparation behaves differently from an isolated molecule. This is a system with real levers on nerves, on immune cells and on the wall, and the state of the human trials is on the previous page. Whatever the product, read the lab report first.

Never make changes to your protocol without consulting your gastroenterologist.



M

BONUS SECTION · FIVE PRODUCTS · NOT PART OF THE HUNDRED

Sleep, Stress & Attention

A gut guide with a brain section, because the two organs run on the same wiring. Chronic stress and broken sleep push inflammation up and the barrier open; inflammation, in turn, dulls the dopamine system that governs attention and drive, which is one reason ADHD and IBD travel together so often. None of the five products here is an IBD supplement, and every one of them is secondary to everything else in this guide. But if you sleep badly, carry stress in your gut, or cannot hold a thought, they have earned their place in my own life, and I think you will find this short section unexpectedly important.

Browse these four in my Fullscript dispensary

go.supplementsforibd.com/sleep-stress-attention

Illustration: the brain between day and night, with a neuron

Never make changes to your protocol without consulting your gastroenterologist.

Section M · Bonus · Sleep, stress & attention

Why a gut guide has a brain section

People tell me the gut is the second brain. I always answer the same way: but the brain is the first brain. Three threads tie the nervous system to the gut wall, and each of them has a supplement or two worth knowing about. Read this page first; the products follow.

Stress, cortisol and the immune system

Cortisol is the body's own anti-inflammatory, which is exactly why prednisone works. But the system is built for short bursts. Under chronic stress, cortisol runs high for too long, the immune cells that should listen to it stop listening (a state researchers call glucocorticoid resistance), and the result is not less inflammation but more, and more disordered. Stress hormones also act directly on the gut: they loosen tight junctions, thin the mucus layer, activate mast cells in the wall, and change which bacteria thrive. In a prospective study of people with IBD, perceived stress was among the strongest predictors of a symptomatic flare in the following months. Trauma, early or recent, leaves this system on a hair-trigger; many of the people I work with can name the stressful season that preceded their diagnosis, and I can name mine. (refs 182–186)

Sleep is not optional in IBD

Sleep is when the immune system is retuned and the barrier is repaired. Poor sleep raises inflammatory cytokines in healthy people within days, and in people with IBD it does worse: in a large cohort, those with disturbed sleep while their Crohn's was quiet had roughly double the odds of active disease six months later. It runs both ways, of course, since night-time symptoms wreck sleep, but that is the point: a night of real rest is a treatment, and protecting it is worth more than most bottles in this guide. Melatonin (C-08) belongs to this conversation, and its entry explains why I treat it as a hormone to be used sparingly. The herbal formula on the next page is what I reach for instead.

Attention, dopamine and inflammation

Attention-deficit/hyperactivity disorder is more common in people with IBD than in the general population, and large registry studies keep finding the two together. Part of the link is shared genetics and part is life with a chronic illness, but part of it is chemistry: inflammatory cytokines reduce the synthesis and release of dopamine and blunt the brain's reward and motivation circuits, which is why sick people feel foggy, flat and unable to focus, and why a flare can feel like an ADHD flare too. Depression overlaps here as well; this guide does not address supplements for depression, and if that is where you are, please talk to your team. What the two amino acids in this section do is nudge the dopamine and calming systems from the supply side: L-tyrosine as the raw material for dopamine, L-theanine as the counterweight that keeps focus from turning into anxiety.

How to use this section

Everything here is a second-order move. Get the medical plan, the food, the movement and the five at the front of this guide in place first. Then, if sleep or stress or attention is the thing standing between you and a good day, these five are gentle, inexpensive and, in my experience, surprisingly effective. Two of them are part of my daily life; the rest are tools I keep in the drawer. The links between stress, sleep, attention and the gut are real; most of what we know is association and mechanism, not proof that a bottle changes the disease, and the pages that follow keep that distinction visible.

How this section is organized. The mechanisms, drawn; a short case for cold brew; the five products; then melatonin and magnesium, repeated here because they belong to this conversation.

The brain that rewires, and why it matters for remission

Everything on this page is changeable, and that is the point of the section. The nervous system is plastic: connections that are used strengthen, connections that are not are pruned, and the stress axis, the sleep rhythm and the attention system are all built from such connections. A brain that has spent years on a hair-trigger was trained there, by circumstance, and it can be trained back. That is not a metaphor. It is long-term potentiation and long-term depression, the two cellular mechanisms drawn on the page "How a connection strengthens," and the growth factor BDNF (brain-derived neurotrophic factor) that governs both, which rises with sleep, movement, learning and time in a rich environment and falls under chronic inflammation and stress.

This is the idea Systema Health is built on. A person with IBD is not a gut with a problem; they are a whole system that has adapted, and adaptation runs in both directions. The five products in this section are small levers on that system. The large levers are the ones you already know: a protected night of sleep, a body that moves outdoors, a practice that quiets the stress axis for twenty minutes a day, work and relationships that do not run you at redline, and the patience to let new wiring form, which takes weeks and months rather than days. When people ask me what human potential has to do with a gut disease, this is the answer. The wall you have read about heals in a body whose nervous system has stopped sounding the alarm, and that nervous system can be taught.

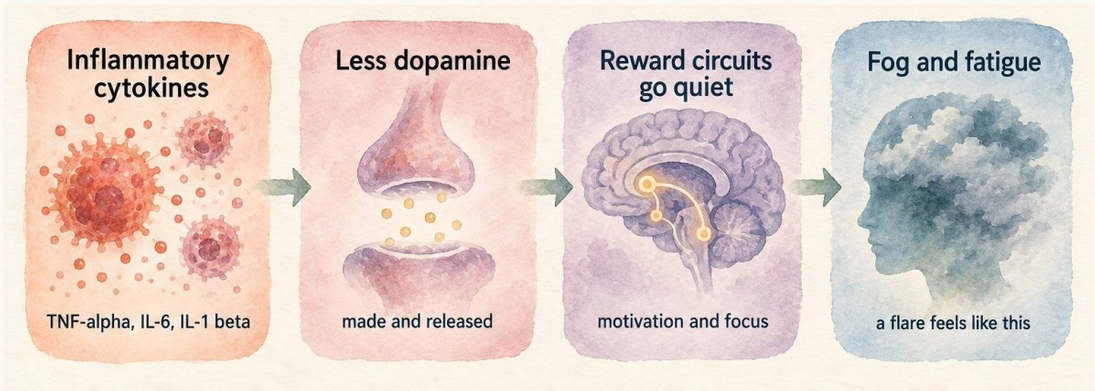
Section M · Bonus · Sleep, stress & attention

Two mechanisms, drawn

The stress hormone that is also the body's steroid, and the chain that turns a cytokine into a foggy afternoon.



Acute versus chronic cortisol. A burst suppresses inflammation; months of it produce receptor resistance, and inflammation rises anyway. This is the mechanism behind the observation that chronic stress may be causative in IBD, not only a consequence of it.



Inflammation and dopamine. Cytokines lower dopamine synthesis and release; dopamine drives motivation and focus; a flare feels like fog and flatness for a chemical reason.

Neuroplasticity

The brain rewires in response to what it is repeatedly asked to do, and inflammation slows that rewiring: chronic cytokine exposure lowers BDNF, the growth factor that lets neurons form new connections. The reverse is also true. Sleep, exercise, learning and a calmer stress axis raise it, which is one reason the habits in this section compound over months rather than days. Polyphenols belong in this conversation too: curcumin, resveratrol, EGCG and the anthocyanins in bilberry cross into the brain in small amounts and act on the same NF-κB and Nrf2 switches there that they act on in the gut wall.

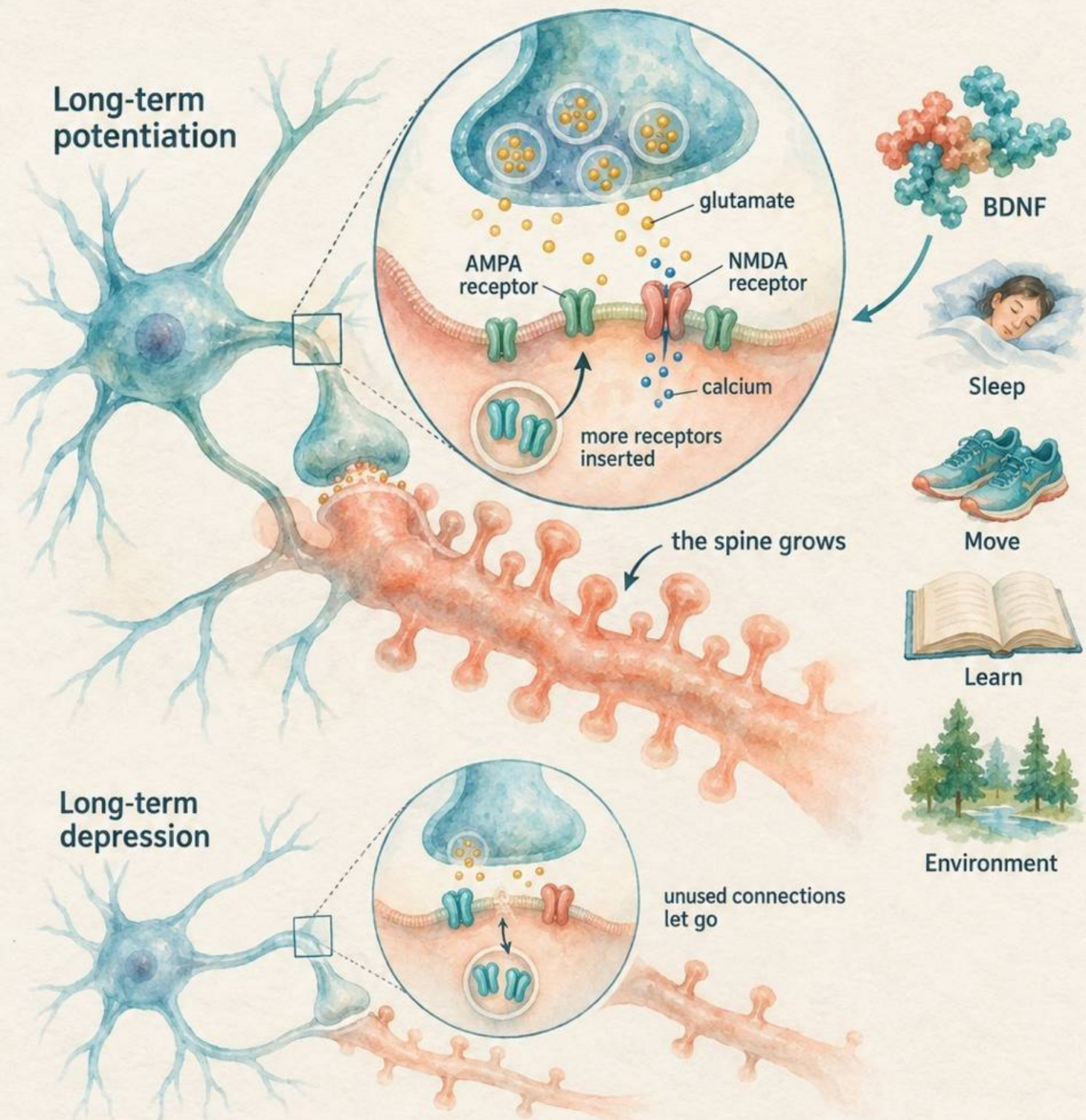
Melatonin, briefly

Melatonin has its full entry at C-08, and I treat it as a hormone rather than a supplement: sparingly, at night, and at far lower doses than most people take. If sleep is the problem, the herbal formula on the following pages is what I reach for first. When melatonin is the right tool, its card is repeated at the end of this section, alongside magnesium glycinate.

How the five products map onto these two drawings

Phosphatidylserine (M-05) and Rescue Remedy (M-02) work on the first drawing, the cortisol curve: one by blunting the hormone's response to a stressor in trials, the other, if it does anything for you at all, by taking the edge off the moment. L-tyrosine (M-04) and L-theanine (M-03) work on the second: the raw material for dopamine when inflammation has run it down, and the calming counterweight that keeps focus from turning into anxiety. The herbal sleep formula (M-01) works on both, because a night of real rest is where the stress axis resets and the reward circuits recover. None of these is the large lever. The large lever is the night's sleep itself, the movement and the practice that quiets the alarm, and the next page shows why those compound.

How a connection strengthens



Every habit in this section works through the picture above. When a signal crosses a synapse often enough, glutamate opens AMPA receptors, calcium enters through NMDA receptors, and the cell answers by inserting more receptors and growing the spine: long-term potentiation, the cellular basis of learning. Connections that go unused run the process in reverse, long-term depression, and are pruned. Brain-derived neurotrophic factor (BDNF), the growth factor drawn at the top right, is the fertilizer for both; it rises with sleep, movement, learning and time in a rich environment, and it falls under chronic inflammation and stress. This is the biology underneath the idea Systema is built on: a body and a brain rewire toward what they are repeatedly asked to do. Remission is a set of connections you strengthen every day, and neuroplasticity is why the effort compounds.

Never make changes to your protocol without consulting your gastroenterologist.

DEPARTMENT · THE COFFEE TAKE

Cold brew, light roast, and a cup of L-theanine



I do not think coffee is as bad for IBD as it is made out to be. Coffee is one of the largest sources of polyphenols in the Western diet, chlorogenic acids above all, and in large cohorts coffee drinkers have less liver disease and, in several studies, lower rates of ulcerative colitis. The problems people have with it are usually three: acidity, the bowel-stimulating effect of a hot cup on an empty stomach, and caffeine's edge.

Each has an answer. **Cold brew** is markedly less acidic than hot-brewed coffee because the bitter acids extract slowly in cold water. **Light roast** keeps more of the chlorogenic acids that dark roasting burns away. And **L-theanine** (M-03), the amino acid that makes green tea calm, takes the jittery, blood-pressure-raising edge off caffeine while keeping the focus; the pairing has randomized trials behind it in healthy adults.

How I do it. A glass of cold brew, light roast, mid-morning rather than first thing, with L-theanine alongside. Not on an empty stomach in a flare, and never as a substitute for water. Adjust the amount to your own caffeine sensitivity, and stop if it clearly bothers your gut; the goal is a good day, not a habit you defend.

The caveats are real. Caffeine is a colonic stimulant, which is a feature in constipation and a fault in a flare. Milk is its own question. And coffee stacks with the sleep problem in this section: nothing after early afternoon if your sleep is fragile.



THE PAIRING · M-03

Pure Encapsulations L-Theanine 400 mg

The amino acid that makes green tea calm. Taken with the coffee it keeps the focus and takes the edge off the caffeine; my score is a 5, and it is the one product in this section I take every day.

Buy on Fullscript →

go.supplementsforibd.com/l-theanine

Illustration: cold brew, painted.

Section M · Sleep, stress & attention · the five products





Passionflower and valerian

M-01 · #bonus

Herbal sleep formula

Gaia Herbs Professional, Sleep Formula (sold retail as Sound Sleep) · 60 liquid phyto-caps

Sleep · stress · attention

An all-herbal formula built around passionflower, valerian, California poppy, skullcap and hops, with vervain, gotu kola and a trace of lavender, extracted into Gaia's liquid capsules. Each of the lead herbs has small randomized trials for sleep onset and quality in other populations; none has been tested in IBD, and none needs to be, because what it is here for is the night, not the gut. Some versions of this blend have included kava root; if yours does, know the FDA's liver caution and keep an eye on those enzymes.

Not with alcohol, benzodiazepines, sleep medications (zolpidem and relatives), opioids or other sedatives: valerian, hops, passionflower and California poppy add to their effect. Not before driving. Not in pregnancy. If the label lists kava: not with liver disease, and keep courses short.

References 187–189

Andrew's notes

As needed, one to three nights a week, never nightly. For me this formula has proved vastly superior to melatonin, which I treat as a hormone rather than a supplement (C-08). A sleep aid is a tool for a bad night, not a habit; the habit is protecting your sleep.

Buy on Fullscript →

go.supplementsforibd.com/sleep-formula

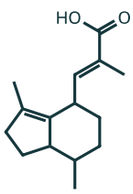
SKU GH-SF

Evidence 2

Adjacent RCTs of the lead herbs for sleep; none in IBD

Andrew's score 4

Andrew's judgment, 1–5.



Valerenic acid, one representative constituent of valerian (not the whole formula) · $C_{15}H_{22}O_2$ · 234.3 g/mol · PubChem CID 6440940





Five flower essences

M-02 · #bonus

Bach flower remedy (Rescue Remedy)

Nelson Bach, Rescue Remedy Spray · 7 mL (20 mL also listed)

Sleep · stress · attention

Five flower essences (rock rose, clematis, impatiens, cherry plum, star of Bethlehem) in a grape-alcohol base, the formula Dr Edward Bach developed in England in the 1930s, in the yellow spray. I'll be plain about the science: a systematic review of the randomized trials found no effect beyond placebo, and this is the least evidence-based product in the entire guide. It stays because it is about as harmless as anything can be, because it costs little, and because it works for me.

Contains alcohol; an alcohol-free version exists. If you need help with anxiety, this is not a treatment for it, talk to your team.

Reference 190

Andrew's notes

Three sprays at bedtime or when I feel anxious, maybe once a week. I know the trial record, and I'll still say it: this is actually quite effective for me at taking the edge off anxious feelings. If it does nothing for you, you have lost very little.

Buy on Fullscript →

go.supplementsforibd.com/rescue-remedy

SKU BA0006 (Fullscript code)

Evidence 1

Randomized trials find no effect beyond placebo

Andrew's score 3

Andrew's judgment, 1–5.

Section M · Sleep, stress & attention · the five products, continued



M-03 · #bonus

L-theanine

Pure Encapsulations, L-Theanine 400 mg · 60 caps

Sleep · stress · attention

The amino acid that makes green tea calming. L-theanine raises alpha-wave activity in the brain within an hour, and in randomized trials it reduced stress-related symptoms and improved attention; paired with caffeine it sharpens focus while blunting the jittery, blood-pressure-raising side of coffee. Suntheanine-grade, single ingredient, no additives of concern. The most useful of the five products here, and the one I would try first.

Very well tolerated. May lower blood pressure slightly; note it if you already run low.

References 191–193

Andrew's notes

I take L-theanine every single day, throughout the day, always. It is an extraordinary tool: focus without the edge, and it simply feels good, especially combined with caffeine. I prefer a spray, because you can dose a puff at a time with your coffee; no spray existed on Fullscript at press time, so the capsule is linked here.

Buy on Fullscript →

go.supplementsforibd.com/l-theanine

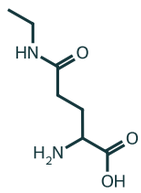
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Evidence 2

RCTs for stress and attention, alone and with caffeine; none in IBD

Andrew's score 5

Andrew's judgment, 1–5.



L-theanine · $C_7H_{14}N_2O_3$ · 174.2 g/mol · PubChem CID 439378



M-04 · #bonus

L-tyrosine

Pure Encapsulations, l-Tyrosine · 90 caps

Sleep · stress · attention

The amino acid the brain turns into dopamine and noradrenaline. In randomized studies, tyrosine preserves working memory and attention when the dopamine system is under load: sleep loss, cold, multitasking, acute stress. There are no good trials in ADHD and none in IBD; the bridge to this guide is mechanistic, since inflammation lowers dopamine tone, which is part of why active disease feels like brain fog. Free-form, taken on an empty stomach so it is not crowded out by other amino acids.

Not with MAOI antidepressants or levodopa; caution with hyperthyroidism or Graves' disease; can raise blood pressure at high doses.

References 194–195

Andrew's notes

On an empty stomach, first thing in the morning, as needed. It does nothing for me taken with food. A slight lift in mood and concentration; it helps my ADHD. Secondary to everything else in this guide.

Buy on Fullscript →

go.supplementsforibd.com/l-tyrosine

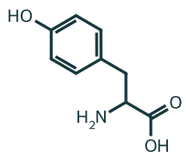
SKU PUR-LTY9

Evidence 2

RCTs under acute stress; none in ADHD or IBD

Andrew's score 4

Andrew's judgment, 1–5.



L-tyrosine · $C_9H_{11}NO_3$ · 181.2 g/mol · PubChem CID 6057

Section M · Sleep, stress & attention · the five products, continued





Sunflower, the soy-free source

M-05 · #bonus

Phosphatidylserine

Integrative Therapeutics, Phosphatidylserine 100 mg (soy-free) · 60 softgels

Sleep · stress · attention

A phospholipid concentrated in cell membranes, and in the brain more than anywhere else. Phosphatidylserine has randomized trials for memory and attention in older adults and for blunting the cortisol response to exercise and mental stress in younger ones; it is one of the few nutrients with a qualified FDA health claim for cognition. In IBD the bridge is mechanistic and indirect: the same stress-cortisol axis described on the previous page, plus its kinship with phosphatidylcholine (F-08), the mucus layer's main phospholipid. Soy-free sunflower-derived form, no additives of concern.

Very well tolerated. Mild insomnia or stomach upset at high doses; separate from blood thinners by a few hours as a precaution.

Andrew's notes

I call phosphatidylserine the baseline cognitive and neuro supplement. It is very safe, there may be some IBD evidence, and it pairs naturally with the phosphatidylcholine in F-08: the two phospholipids belong to the same membranes. If attention, stress or recovery is the thing you are working on, this is where I would start, and it sits underneath everything else in this section.

Buy on Fullscript →

go.supplementsforibd.com/phosphatidylserine

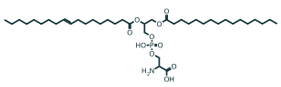
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Evidence 2

RCTs for cognition and the stress response; none in IBD

Andrew's score 5

Andrew's judgment, 1–5.



A phosphatidylserine (POPS) · $C_{40}H_{76}NO_{10}P$ · 762 g/mol · PubChem CID 5283499

Also part of this conversation: melatonin (C-08) and magnesium (J-05)

Melatonin stays in Section C because its one IBD trial is an anti-inflammatory one, and magnesium stays in Section J because it is repletion, but both belong to a conversation about sleep, so their cards are repeated on the next page. My melatonin note is on its card: use it very carefully and sparingly, at night, especially for jet lag; it is far more a hormone than a supplement, and people take far too much of it. The formula above (M-01) is what I reach for instead.

The five products in this section are outside the hundred and carry no display number. Evidence bars use the same 1–5 scale (human IBD data) as the rest of the guide, which is why they sit low: these are not IBD supplements, and the guide does not pretend otherwise. Fullscript listings for this section were confirmed by catalog search; SKUs and pack sizes are re-checked at each edition.

Section M · Sleep, stress & attention · two entries repeated here, by design

These two supplements have their homes elsewhere in the guide and keep their stable IDs, evidence bars and links; they are repeated here because this is where people look for them when the problem is a night's sleep. Neither adds to the hundred.





Tart cherries, a food source

C-08 · #13

Melatonin

Klaire Labs / SFI Health, Melatonin Lozenge 1 mg (cherry, dissolve or chew) · 60 lozenges

Inflammation · Barrier

Not just a sleep hormone, the gut makes far more melatonin than the pineal gland, and it acts on the gut wall directly. A randomized UC trial found melatonin as an adjunct to mesalamine helped maintain remission. Sleep loss is itself pro-inflammatory. The product is deliberately a 1 mg lozenge you dissolve or chew; in my experience people do best on 1 mg or less, and most bottles start at 3 mg.

Label flags autoimmune disease and corticosteroid use as cautions, talk to your team. Contains mannitol and magnesium stearate; the label carries a wheat statement.

Reference 61

Andrew's notes

Use this very carefully and sparingly, at night. It's especially good for jet lag. In my opinion it is much more a drug and a hormone than a supplement, and people generally take far too much; in my experience 1 mg is often plenty, which is why the product I link is a 1 mg lozenge.

Buy on Fullscript →

go.supplementsforibd.com/melatonin

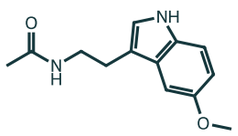
SKU KLP-ML1

Evidence 4

One positive RCT in UC

Andrew's score 2

Andrew's judgment, 1–5.



Melatonin · $C_{13}H_{16}N_2O_2$ · 232.3 g/mol · PubChem CID 896



J-05 · #83

Magnesium

Pure Encapsulations, Magnesium (glycinate) 120 mg · 90 caps

Replenish · Inflammation

Magnesium glycinate, the form least likely to loosen stool, 120 mg of elemental magnesium per capsule with nothing else but the capsule and a trace of ascorbyl palmitate; label checked September 2026. In Section J it is repletion: magnesium is lost in diarrhea and needed to activate vitamin D. Here it is a sleep tool: small randomized trials in older adults with insomnia found modest improvements in sleep onset and quality, and glycine, its carrier here, has small trials of its own for sleep quality. Neither is IBD evidence, and the effect is gentle.

Loose stool is the dose-limiting effect even with glycinate; back off if it appears. Separate from some antibiotics and bisphosphonates by a few hours. Kidney disease: ask first.

Reference 142

Andrew's notes

Glycinate is the form I point people to whenever magnesium is the question, because it is the one least likely to loosen stool in a gut that is already loose. I take it before bed, and for me it is one of the quiet workhorses of the regimen: gentle, cheap, and noticeable in sleep quality within a couple of weeks. The sleep evidence is modest and comes from other populations, so my 4 is about what I see, not about a trial in IBD.

Buy on Fullscript →

go.supplementsforibd.com/magnesium

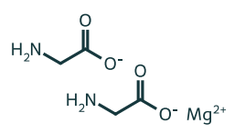
SKU PUR-MG9

Evidence 3

Repletion evidence in IBD (Section J row); sleep evidence is small RCTs in other populations

Andrew's score 4

Andrew's judgment, 1–5.



Magnesium glycinate · $C_4H_8MgN_2O_4$ · 172.4 g/mol · PubChem CID 84645



N

SECTION N · REFERENCE · NINE PAGES

Building Your Regimen

How to turn a hundred entries into a list you would actually take. A hundred is a menu, not a shopping list, and this is the part of the guide where the menu becomes a plan. It opens with the situational additions: what to consider first in ulcerative colitis, in Crohn's, in indeterminate and microscopic colitis, in a flare and in remission, after surgery, on steroids and after a J-pouch, because the Five are the Five for everyone and everything after them depends on where you are. Then stacking and sequencing: one new thing at a time, on a stable foundation, with a budget tier for every wallet, and the reasons a regimen that leans gently on many mechanisms beats one that leans hard on one. Then the interactions table for the IBD medications, consolidated so your team can read it in a minute. Then the four questions I ask before anything goes in the cabinet, and, for the first time in print, my own protocol and the thinking behind it, with a sample of how I move it up and down through a flare and the as-needed drawer I keep for bad days. A page on using AI to build a protocol well, and the full capability matrix, a hundred entries against five mechanisms on two pages, close the section and the guide. Bring the result to your gastroenterologist as a table. A table is harder to dismiss than a bag of bottles.

IN THIS SECTION

Situational additions by phenotype 108 Stacking, sequencing and budget 109
Interactions with IBD medications 110 The four questions 111 My personal protocol 112
The as-needed drawer and a flare protocol 113 The capability matrix 114 Using AI to build your protocol 116

Illustration: a regimen someone would actually keep

Never make changes to your protocol without consulting your gastroenterologist.

Section N · Building Your Regimen

Situational additions by phenotype

Curcumin, quercetin and the rest of the Five are the base regardless of diagnosis. Beyond them, which entries are worth reading first depends on which disease you have and where you are in it. This page is a reading map, not a protocol.

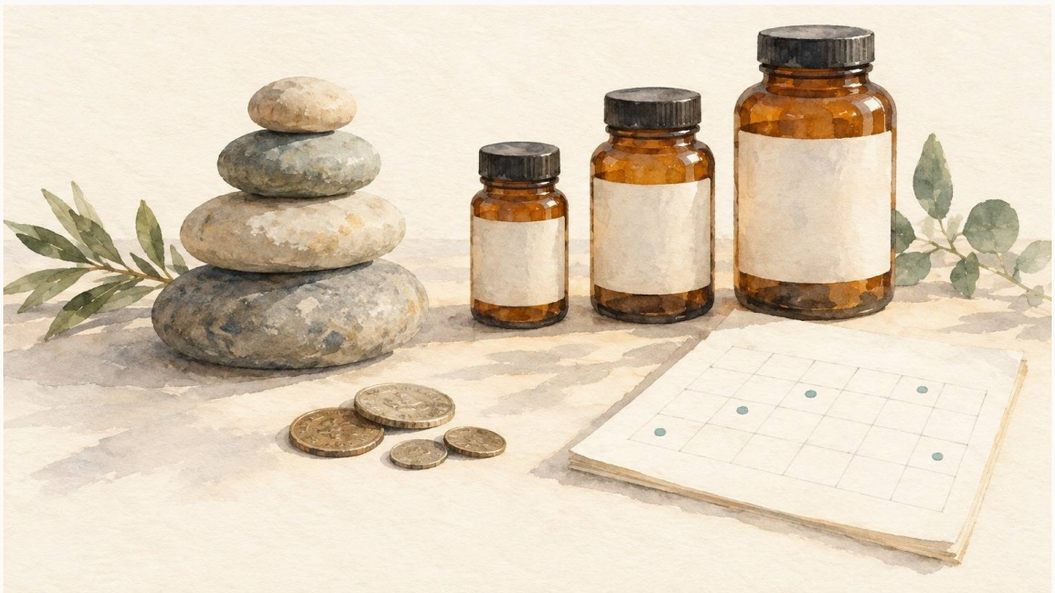
	Situation	What is different about it	Entries worth reading first
	**Ulcerative colitis**	Disease of the colon and rectum. The colonocyte runs on butyrate; the mucus layer's phosphatidylcholine is depleted; most of the positive randomized curcumin and aloe trials are in UC.	A-01 curcumin · A-03 omega-3 (EPA) · F-02 butyrate · F-08 phosphatidylcholine · D-07 psyllium · F-04 aloe vera · D-01 Akkermansia
	**Crohn's disease**	Anywhere from mouth to anus, most often the terminal ileum. Small-bowel involvement means the enterocyte (glutamine) and fat-soluble-vitamin and B12 absorption are the issues; strictures change what fiber is safe.	A-05 vitamin D3 · A-04 SBI · F-01 glutamine · E-04 wormwood (the Crohn's RCTs) · J-02 B12 · J-01 iron · J-04 zinc
	Indeterminate colitis	Colitis that biopsy cannot yet call Crohn's or UC; often reclassified later, and often first diagnosed in children. Until it declares itself, you are reading two evidence columns at once.	Read the UC and Crohn's rows above as both potentially yours. Start with the Five, then Section F (barrier), whose mechanisms apply whichever way the diagnosis settles. Recheck the diagnosis with your gastroenterologist at each scope.
	**Microscopic colitis**	Collagenous or lymphocytic; a normal-looking colon, watery non-bloody diarrhea, skewing older and female. Budesonide is first-line and works. The evidence bars in this guide were not earned here, and mesalamine's weaker showing in MC is the reminder that UC data does not transfer by default.	C-02 boswellia, the only entry with an MC trial. A-04 for stool consistency. A-05 for bone protection during budesonide. Psyllium (D-07) over the probiotics; the AGA suggests against probiotics for MC. Ask about medication triggers (PPIs, NSAIDs, SSRIs), celiac screening and bile-acid malabsorption.
	**Active flare**	Nothing in this guide is a flare rescue, and the trials weren't designed that way. During a flare the priorities are the medical plan, hydration, electrolytes and not adding anything new. Insoluble fiber and fermentable prebiotics often worsen symptoms in active disease.	J-20 potassium · J-05 magnesium · F-01 glutamine (well tolerated) · A-04 SBI · H-01 peppermint (cramping, if coating holds), and a pause on Section D fibers
	**Remission / maintenance**	This is where the evidence is strongest. The curcumin maintenance trial, the vitamin D relapse trials, the EPA calprotectin trial and the psyllium maintenance trial were all in patients already in remission.	A-01 curcumin · A-05 vitamin D3 · A-03 omega-3 · D-07 psyllium · Section D prebiotics, introduced slowly
	**Post-operative (resection)**	Absorption changes depending on what was removed: terminal ileum → B12, bile acids, fat-soluble vitamins; large resections → magnesium, zinc. Note that high-dose vitamin D did *not* prevent post-op Crohn's recurrence in the one trial that tested it.	J-02 B12 · J-05 magnesium · J-04 zinc · A-05 vitamin D3 (for repletion, not recurrence) · E-04 wormwood (post-op data) · F-03 creatine
	**Steroid taper**	Corticosteroids accelerate bone loss, raise vitamin D requirements, raise blood sugar and lower potassium. Wormwood's two RCTs were specifically steroid-sparing designs.	A-05 vitamin D3 · J-07 calcium · J-15 vitamin K · J-05 magnesium · J-20 potassium · E-04 wormwood
	**Pouchitis (after J-pouch)**	Inflammation of the ileal pouch. The best-evidenced supplement here (the VSL#3/Visbiome multi-strain probiotic) is not on the dispensary and appears in the closing table; inulin has pilot data.	D-09 inulin/FOS · F-02 butyrate · A-01 curcumin, and see Visbiome in "didn't make the cut"

The Five have full three-page entries in Section A; every other entry has a product card or a list row in its own section, with its evidence and my score.

Section N · Building Your Regimen

Stacking, sequencing and budget

A hundred entries is a menu, not a shopping list. Most people will take between two and six of them. Here is how to think about which, in what order, and what to do when money is the constraint.



Sequencing: one at a time

Add one new thing at a time and give it two to four weeks before the next. The reason is diagnostic: if you start three supplements in a week and feel worse, you have no idea which one did it, and you'll probably stop all three, including the two that were helping. Every trial in this guide tested a single agent against a stable background. Copy that design.

Stacking: cover different mechanisms

Two entries from the same mechanism bucket are usually redundant; two from different buckets are usually complementary. An anti-inflammatory (Section A or C), something that feeds the microbiome (D) and something for the barrier (F) address three points on the loop. Four different antioxidants address one point four times. The capability matrix exists for exactly this check.

Combination products

I prefer single-ingredient products almost everywhere in this guide: you can adjust one without the other, and you can tell which is doing what. The two exceptions are deliberate, the multivitamin (J-00), and the peptide combo (G-01/G-02), where the two peptides are meant to travel together.

The doubling-up problem

Many products carry extra ingredients, a multivitamin with 2,000 IU of vitamin D, a fish oil with added D3, a "gut repair" powder with a gram of glutamine. Add these up on one tracking sheet (see the four questions). If you take a multivitamin, it is the first row.

Budget tiers

Tier	What it looks like
If you can only afford one	**Curcumin.** It has the deepest trial record of anything here, in both diseases, and it addresses the mechanism (inflammation) that does the damage. Thorne Curcumin Phytosome: go.supplementsforibd.com/curcumin
Foundation (2–3)	One anti-inflammatory from the Five, vitamin D3 guided by a blood level, and one barrier entry. For most people this is where the value is.
Full Five	All five, added one at a time over two to three months. Omega-3 and SBI at study-range intakes are the expensive lines; the powder form of SBI and a concentrated fish oil bring both down.
Extended	The Five plus phenotype-specific additions from the previous page, chosen with your health team against the matrix. Rarely more than eight total.

Prices are not listed in this guide by design, they live on the dispensary. The tiers are about number of products, not dollars.

Food first, always

Several entries can be had as food or tea at near-zero cost: turmeric in cooking (with the absorption caveat), fatty fish twice a week, red onion and capers for quercetin, ginger tea, chamomile tea, bone broth for glycine and collagen, sunlight for vitamin D. The whole-food line in every full entry exists so you can check that before you buy anything.

What I personally take, and why, is two pages further on in this section, labeled as exactly that.

Section N · Building Your Regimen

Interactions with IBD medications

Consolidated for the Five; the individual product cards carry the cautions for the rest. Three general rules first, then the specifics.

Rule 1, the calcineurin inhibitors

Tacrolimus and cyclosporine have narrow therapeutic windows and are cleared by CYP3A4 and P-glycoprotein. Several polyphenols in this guide inhibit both in laboratory studies. If you are on either drug, every new supplement goes past your prescriber first.

Rule 2, anticoagulants

Curcumin, quercetin, omega-3, ginger, garlic and vitamin E all have antiplatelet activity. Alone, minor. Stacked, or on top of warfarin or a DOAC, worth a conversation, and worth stopping before surgery or a colonoscopy with polypectomy.

Rule 3, steroids raise requirements

Prednisone and budesonide increase your need for vitamin D, calcium, potassium and magnesium and accelerate bone loss. This is the most consequential "interaction" in the table and it runs in the opposite direction from the others.





Entry	Mesalamine / sulfasalazine	Thiopurines, methotrexate	Corticosteroids	Tacrolimus, cyclosporine	Biologics, JAK inhibitors	Other notable
A-01 Curcumin	Co-administered in every UC trial; no problem seen	—	—	**Caution**, CYP3A4/P-gp inhibition in vitro; may raise levels	—	Anticoagulants (additive); iron absorption ↓
A-02 Quercetin	—	—	—	**Caution**, CYP3A4/P-gp inhibition; may raise levels	—	Anticoagulants (additive); some quinolone antibiotics
A-03 Omega-3	—	—	—	—	—	Anticoagulants/antiplatelets (additive); antihypertensives (mild)
A-04 SBI	No known interaction (no dedicated study). EnteraGam's maker reports no significant drug interactions and no need to separate doses; SBI acts inside the gut and isn't absorbed. Follow your mesalamine's own instructions.	—	—	—	Added on top of biologics in the case series	Beef allergy, alpha-gal syndrome
A-05 Vitamin D3	—	—	**Steroids raise vitamin D need** and bone loss	—	—	Cholestyramine (absorption ↓, separate by hours); thiazides (calcium ↑)

"—" means no interaction has been documented, not that one has been ruled out. Sources: the trial reports cited in each entry and standard interaction references.

Section N · Building Your Regimen · an exercise

The four questions

A process for turning a hundred options into a short list you can discuss with your health team. Do it on paper. Bring the paper.



1 Stand-outs

Which entries stand out to you, and why? Pick two to ten to examine further. Write the "why" down; if it's "someone in a forum said so," fine, but it should be visible to you.

2 Food as a foundation

Am I already practicing a dietary and nutritional strategy? Which of these entries can I get from whole foods or teas first? Cross anything off the list that you can eat instead of swallow.

3 My health team

What has my gastroenterologist, primary-care physician, dietitian, or naturopathic/integrative physician recommended, and why? Ask for the mechanism or their experience with other patients. If two of them contradict each other, ask *why*; one answer is almost always more reasonable, and the "why" tells you which.

4 Science

What is the level of evidence? Is there direct evidence in IBD, or only in humans with other conditions, or only in mice, or only in a dish? Does it prevent disease in a model or reduce activity in people who already have it? How many studies, and in Crohn's or UC? The evidence bar on each entry is this question, pre-answered, but check it against the studies listed, because that is what the bar is for.

If you would like a hand working through the four questions, an AI assistant can do the first pass with you; the page **"Using AI to build your protocol"** gives you the prompt and its limits. And if you would rather do it with a person, that is what a free analysis call with Systema is for: **systema.health/apply-now**.

Then: the tracking sheet

For every supplement, vitamin or herb you take, one row: the product, the brand, every active ingredient and its dose, and what time of day you take it. Total each active ingredient across rows, this is where you discover that your multivitamin, your fish oil and your bone formula each contain vitamin D and you're taking three times what you thought. The AI page builds this sheet as a table for you if you give it your list; check its totals against the labels.

Bring the sheet to every appointment. A table with doses on it is much harder to dismiss than a bag of bottles.

Two temperaments

Some people take a "kitchen sink" approach (several well-tolerated things at once) and some take a "slow and steady" approach, one change at a time. The kitchen sink gets you somewhere faster and can leave you with no idea what's working. Slow and steady is diagnostically cleaner and feels unbearably slow when you're unwell. Know which one you are, and know the trials in this guide were all designed the slow way.

Go to my Fullscript dispensary

go.supplementsforibd.com/dispensary · every product in this guide, organized by section

A systems view

Go back to the five mechanisms and ask how your list addresses them. It rarely makes sense to take three things that all quiet inflammation and nothing that feeds the microbiome or supports the barrier. Balance across the loop is worth more than depth at one point on it.

Section N · Building Your Regimen

My personal protocol, and why

This is what I take, as one person with Crohn's disease, and it is here so you can see how a protocol gets *constructed*, not so you can copy it. Every item links to Fullscript because that is where I buy it.

Don't copy this exactly. Use it as inspiration. My protocol reflects my disease (ileal Crohn's, in remission), my labs, my diet, my training load and years of trial and error with my team. Yours should reflect yours. What I want you to take from these two pages is the *shape* of it: a small non-negotiable core, a second ring that flexes with how I feel, and a drawer of as-needed tools. Discuss anything here with your gastroenterologist before it goes near your mouth.

How I built it. The Five are my non-negotiables; they cover inflammation, the barrier and the lumen, and they are the last things I would ever drop. Around them sit the entries that cover different points on the loop from Section B: fuel for the lining, the mucus layer, a few polyphenols that lean on cytokines curcumin doesn't, one probiotic, and repletion. Then the as-needed drawer. I keep the total lower than it looks: several of these are every-other-day or every-third-day, I taper as I feel better, and on a rest day I sometimes take nothing at all. The photos are the exact products I buy; where the product I actually use is not on Fullscript, the row says so.

	What	How I take it	Why it is in my protocol	Link
	THE NON-NEGOTIABLE CORE · THE FIVE			
	Curcumin · A-01	1–3 caps daily	The anti-inflammatory backbone, and the entry with the deepest trial record in both diseases. Phytosome form, always.	go.supplementsforibd.com/curcumin
	Quercetin · A-02	1–3 tabs daily, by feel	Repair Guard. The most powerful supplement I know for IBD; this is the one I move first when a flare threatens (next page).	go.supplementsforibd.com/quercetin
	Omega-3 · A-03	1–2 softgels daily	Depending on how much fish I have eaten that week. Triglyceride form.	go.supplementsforibd.com/omega-3
	Bovine immunoglobulins · A-04	2 caps daily	Binds bacterial toxins before they reach the wall; firms stool. One of the few things here with human data in refractory IBD.	go.supplementsforibd.com/bovine-immunoglobulin
	Vitamin D3 · A-05	5,000 IU daily	Guided by my blood level, which I want at the upper end of normal. Rechecked at least yearly.	go.supplementsforibd.com/vitamin-d3
	THE SECOND RING · BARRIER, MUCUS, POLYPHENOLS, MICROBIOME, REPLETION			
	L-glutamine · F-01	2,000 mg daily	Fuel for the small-intestinal lining, which is where my Crohn's lives. Safe, cheap, boring, effective for me.	go.supplementsforibd.com/glutamine
	Phosphatidylcholine · F-08	daily	The mucus layer's main phospholipid. The drug-form trial failed, but I continue to believe it has a positive benefit on me.	go.supplementsforibd.com/phosphatidylcholine
	Resveratrol · C-06	daily	After bilberry's anthocyanins, the polyphenol I have noticed the most from; it leans on cytokines curcumin does not.	go.supplementsforibd.com/resveratrol
	Bilberry · C-01	1 cap daily	The most potent anthocyanin source I know of, with the open-label UC data to match.	go.supplementsforibd.com/bilberry
	Medicinal mushrooms · C-16 to C-20	every other day	Host Defense Stamets 7, Paul Stamets' daily blend of seven species; the β-glucans feed the microbiome and train innate immunity.	go.supplementsforibd.com/seven-mushroom-blend
	Probiotic · D-04	1 cap daily	The one multi-strain product I trust. Not a believer in probiotics generally, but this profile earns its place.	go.supplementsforibd.com/probiotic-50b
	Multivitamin · J-00	1 cap every 3rd day	Repletion insurance without overdoing B12 or fat-soluble vitamins; see the doubling-up rule.	go.supplementsforibd.com/multivitamin
	Vitamin C · J-12	every other day, before exercise	PERQUE Potent C Guard, a buffered powder in cold water before I train. Intense exercise transiently loosens the gut barrier, and vitamin C blunted a marker of that leak in a small study of healthy volunteers, a tip I first read in the Briggs paper. (refs 180–181)	go.supplementsforibd.com/potent-c-guard
	L-theanine · M-03	daily, through the day	Always, and especially with coffee. An extraordinary tool for focus without the edge; it simply feels good. What I actually use is the GIVOL spray, which is not on Fullscript; this capsule is the Fullscript option.	go.supplementsforibd.com/l-theanine

Section N · Building Your Regimen

The as-needed drawer, and a sample flare protocol

The rest of what I keep on hand, and then the part people ask me about most: how the core moves when a flare threatens. A sample, designed for me, shown so you can see the logic.

	What	How I take it	Why it is in the drawer	Link
AS NEEDED				
	BPC-157 + KPV · G-01, G-02	as needed	For repair when something is off. I have known BPC-157 a long time; I am still testing how the KPV in this combination affects me.	go.supplementsforibd.com/bpc-kpv
	Bromelain · H-04, papaya enzymes · H-03	as needed, with meals	When digestion is sluggish or a meal was ambitious. Bromelain between meals doubles as an anti-inflammatory.	go.supplementsforibd.com/bromelain go.supplementsforibd.com/papaya-enzyme
	Amino complex · I-01	as needed	Free-form aminos in a smoothie on days when protein is not going down well, or after hard training.	go.supplementsforibd.com/amino-complex
	L-tyrosine · M-04	as needed, empty stomach, morning	For attention on days I need it. Does nothing for me with food.	go.supplementsforibd.com/l-tyrosine
	Sleep Formula · M-01	1–3 nights a week	The herbal formula that has served me far better than melatonin. Never nightly.	go.supplementsforibd.com/sleep-formula
	Rescue Remedy spray · M-02	about once a week	The yellow relaxing spray, at bedtime or when anxious. Small, gentle, and it works for me.	go.supplementsforibd.com/rescue-remedy

A sample flare protocol (mine, not yours)

The medical plan comes first at every stage, and my gastroenterologist knows this table. The supplement adjustments are the second layer, made with that agreement, and they are mine, built over years for my disease; they are not an instruction for anyone to escalate on their own, and worsening symptoms are a reason to call your team, not to wait and see. I catch symptoms early and adjust gently; the biggest single move is quercetin.

	Remission · where I live	First signs · a few days of early symptoms	Flare · moderate symptoms persisting
Medical team	GI twice a year; labs once or twice a year (CBC, CRP, calprotectin, vitamin D, iron, liver enzymes)	Note the date. Tighten everything below for two weeks; if it does not settle, my GI hears from me	Call my GI. Labs and calprotectin now. Medication step-up is a real option, and I have used steroids to break flares before
Quercetin · A-02	1–3 tabs	3–4 tabs	4–5 tabs; 6 in a very serious flare, never the label's 12
Curcumin · A-01	1–2 caps	2–3 caps	3–4 caps, split, with food
L-glutamine · F-01	2 g	4 g	6 g (two scoops), morning and evening
SBI · A-04	2 caps	4 caps	Switch to the powder, 5 g a day, the dose in the refractory-IBD series
Bilberry · C-01, resveratrol · C-06	1 cap each	2 bilberry, 1 resveratrol	2 and 1–2; the polyphenol layer widens
Omega-3, D3, PC · A-03, A-05, F-08	As on the previous page	Unchanged; 2 omega-3 if I have stopped eating fish	Unchanged. These are slow levers; I do not raise them for a flare
Probiotic · D-04, mushrooms	Daily · every other day	Unchanged	Hold both if they seem to bother me; add back last
BPC-157 + KPV · G-01	None	Start, per label	Daily per label until settled
Food	Relaxed SCD-style; eating out is fine; nothing late at night	Strict foundational diet: cooked, soft, low-residue; two meals in an eight-hour window; bone broth	Very strict, puréed textures, broth-heavy; with my team, a one-to-two-day gut rest is on the table
Body & mind	Hard training 5–6 days a week; meditation most days; vitamin C before exercise; lights out by 11	Gentler: walks, yoga, mobility; meditation daily; sleep protected; L-theanine through the day	Rest. Sleep as the priority, sleep formula if needed; no intense exercise until settled

Quantities refer to the exact products on these two pages. As I settle back into remission I walk every one of these back down, one at a time, over two to four weeks.

Section N · reference · page 1 of 2

The capability matrix, 100 × 5

Each entry's five mechanism slots, left to right: **I** control inflammation · **N** nourish the microbiome · **M** modulate the microbiome · **B** repair the barrier · **R** replenish nutrients. Filled dot = primary mechanism; ring = secondary. Entries 1–50.

ID	Entry	I	N	M	B	R
A. The Five						
A-01	Curcumin	●	○		○	
A-02	Quercetin	●	○		○	
A-03	Omega-3 EPA/DHA	●			○	
A-04	SBI (bovine IgG)	○		○	●	
A-05	Vitamin D3	●			○	○
C. Anti-Inflammatories						
C-01	Bilberry	●	○		○	
C-02	Boswellia	●				
C-03	Andrographis	●				
C-04	Green tea / EGCG	●	○	○		
C-05	Ginger	●				
C-06	Resveratrol	●	○			
C-07	Mastic gum	●		○		
C-08	Melatonin	●			○	
C-09	PEA	●				
C-10	NAC	●			○	
C-11	Glutathione (liposomal)	●				
C-12	Alpha-lipoic acid	●				
C-13	CoQ10	●				
C-14	Rutin	●	○			
C-15	Sulforaphane	●			○	
C-16	Reishi	●	○			
C-17	Turkey tail	●	○			
C-18	Lion's mane	●	○			
C-19	Cordyceps	●	○			
C-20	Maitake	●	○			
C-21	Shiitake	●	○			
C-22	Milk thistle	●	○			
C-23	Cat's claw	●				
D. Microbiome Nourishing						
D-01	Akkermansia muciniphila		●		○	
D-02	S. boulardii	○	●		○	
D-03	Spore-based probiotics		●	○		
D-04	Multi-strain L+B	○	●			
D-05	L. reuteri	○	●			
D-06	L. plantarum 299v		●		○	
D-07	Psyllium		●		○	
D-08	PHGG		●			
D-09	Inulin / FOS		●			
D-10	GOS		●			
D-11	Resistant starch		●		○	
D-12	Larch arabinogalactan	○	●			
D-13	Acacia gum		●			
D-14	Lactoferrin	○	●	○		
D-15	Beta-glucan	○	●			
E. Microbiome Modulating						
E-01	Berberine	○		●		
E-02	Oregano oil			●		
E-03	Garlic / allicin	○		●		
E-04	Wormwood	○		●		
E-05	Thyme oil			●		
E-06	Olive leaf extract	○		●		
E-07	Caprylic / monolaurin			●		

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Section N · reference · page 2 of 2

The capability matrix, 100 × 5 (continued)

Each entry's five mechanism slots, left to right: **I** control inflammation · **N** nourish the microbiome · **M** modulate the microbiome · **B** repair the barrier · **R** replenish nutrients. Filled dot = primary mechanism; ring = secondary. Entries 51–100.

ID	Entry	I	N	M	B	R
F. Barrier Repair						
F-01	L-glutamine	○	○	○	●	○
F-02	Butyrate	○	◎	○	●	○
F-03	Creatine	○	○	○	●	○
F-04	Aloe vera (inner leaf)	○	○	○	●	○
F-05	Zinc carnosine	○	○	○	●	○
F-06	N-acetylglucosamine	○	○	○	●	○
F-07	Bovine colostrum	○	○	◎	●	○
F-08	Phosphatidylcholine	○	○	○	●	○
F-09	Collagen peptides	○	○	○	●	◎
F-10	Slippery elm	○	○	○	●	○
F-11	Marshmallow root	○	○	○	●	○
F-12	DGL licorice	○	○	○	●	○
F-13	Chamomile	○	○	○	●	○
G. Peptides						
G-01	BPC-157	○	○	○	●	○
G-02	KPV	●	○	○	◎	○
H. Digestive Support & Enzymes						
H-01	Peppermint oil	○	○	●	○	○
H-02	Digestive enzymes	○	○	●	○	○
H-03	Papain	○	○	●	○	○
H-04	Bromelain	●	○	◎	○	○
H-05	Lactase	○	○	●	○	○
H-06	Alpha-galactosidase	○	○	●	○	○
H-07	DAO	●	○	○	○	○
H-08	Betaine HCl	○	○	●	○	○
I. Amino Acids						
I-01	Tryptophan	◎	●	○	○	◎
I-02	Arginine	○	○	○	●	◎
I-03	Glycine	●	○	○	○	◎
I-04	Cysteine / methionine	●	○	○	○	◎
I-05	Histidine	●	○	○	○	◎
J. Vitamins & Minerals						
J-01	Iron	○	○	○	○	●
J-02	Vitamin B12	○	○	○	◎	●
J-03	Folate (B9)	○	○	○	◎	●
J-04	Zinc	◎	○	○	◎	●
J-05	Magnesium	◎	○	○	○	●
J-06	Vitamin A	◎	○	○	◎	●
J-07	Calcium	○	○	○	◎	●
J-08	Thiamine (B1)	○	○	○	○	●
J-09	Riboflavin (B2)	○	○	◎	○	●
J-10	Niacin (B3)	◎	○	○	○	●
J-11	Selenium	◎	○	○	○	●
J-12	Vitamin C	◎	○	○	○	●
J-13	Vitamin E	◎	○	○	○	●
J-14	Vitamin B6	◎	○	○	○	●
J-15	Vitamin K2	◎	○	○	○	●
J-16	Biotin (B7)	○	○	○	○	●
J-17	Pantothenic acid	○	○	○	○	●
J-18	Choline	○	○	○	◎	●
J-19	Copper	○	○	○	○	●
J-20	Potassium	○	○	○	○	●
J-21	Iodine	○	○	○	○	●
J-22	Manganese	○	○	○	○	●

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Section N · Building Your Regimen · a new tool, used well

Using AI to build your protocol

You can upload this guide to Claude, ChatGPT, Gemini or Grok, give it your full case, and work through a protocol with it in an afternoon. It is a remarkable tool. It is also not your doctor, and neither am I. Here is how I would do it.

Why this works now

A hundred entries, two scores each, an interactions table, a capability matrix and a phenotype map are a lot to hold in your head. A modern AI assistant can hold all of it at once, cross-reference your case against it, and answer the question you actually have: "given my disease, my medications and my budget, which three of these should I read first, and in what order would I try them?" Because every entry carries a stable ID, the model can cite the exact page, and you can check it.

What context to give it

1 **Diagnosis and disease location**
Crohn's, UC, indeterminate or microscopic; ileal, colonic, left-sided, pancolitis; when you were diagnosed and what your last scope showed.

2 **Medications, with doses**
Everything, including the ones you stopped and why. This is where the interactions table earns its keep.

3 **Labs**
CRP, fecal calprotectin, ferritin, B12, vitamin D, liver enzymes, a recent blood count. Numbers, not adjectives.

4 **Diet, symptoms, budget**
What you actually eat, what you cannot tolerate, how many bowel movements, pain, energy, sleep, and how many products you can afford at once.

5 **What you already take**
The tracking sheet from the four questions. If you do not have one yet, this conversation will build it.



The prompt

```
Upload this PDF, then paste:

I have [diagnosis], located in [location], diagnosed
in [year]. My last colonoscopy in [month/year] showed
[findings]. I take [medications and doses]. My recent
labs: CRP [ ], fecal calprotectin [ ], ferritin [ ],
vitamin D [ ], B12 [ ], ALT/AST [ ]. I eat [diet]; I
cannot tolerate [foods]. Symptoms right now: [bowel
movements per day, blood, pain, energy, sleep].
Budget: about [number] products at a time.

Using ONLY the attached guide, "100 Supplements for
IBD":
1. Read Section B and Section N first, then map my
case against the phenotype table.
2. Propose a short list of 3 to 6 entries to read, by
stable ID, with the page number and a one-line reason
for each. Cover different points on the loop in
Section B, not several entries doing the same job.
3. For each, quote the evidence score, Andrew's
score, the dose as studied, and every caution and
interaction the guide lists against my medications.
4. Tell me what to add first and what to wait on, one
change every two to four weeks.
5. Build my tracking sheet as a table: product,
brand, active ingredients and doses, time of day, and
the totals per nutrient.
6. List every question I should bring to my
gastroenterologist before starting.

Do not invent studies or products that are not in the
guide. If the guide does not cover something, say so.
```

Then take it to the room

Print the output. Bring it, with the tracking sheet, to your gastroenterologist, your GP or your integrative practitioner, and let them edit it. An AI cannot see your scope, your labs in context or your history the way they can, and it will sometimes be confidently wrong. The point is not to replace the appointment. It is to walk in with a page of good questions instead of a bag of bottles.

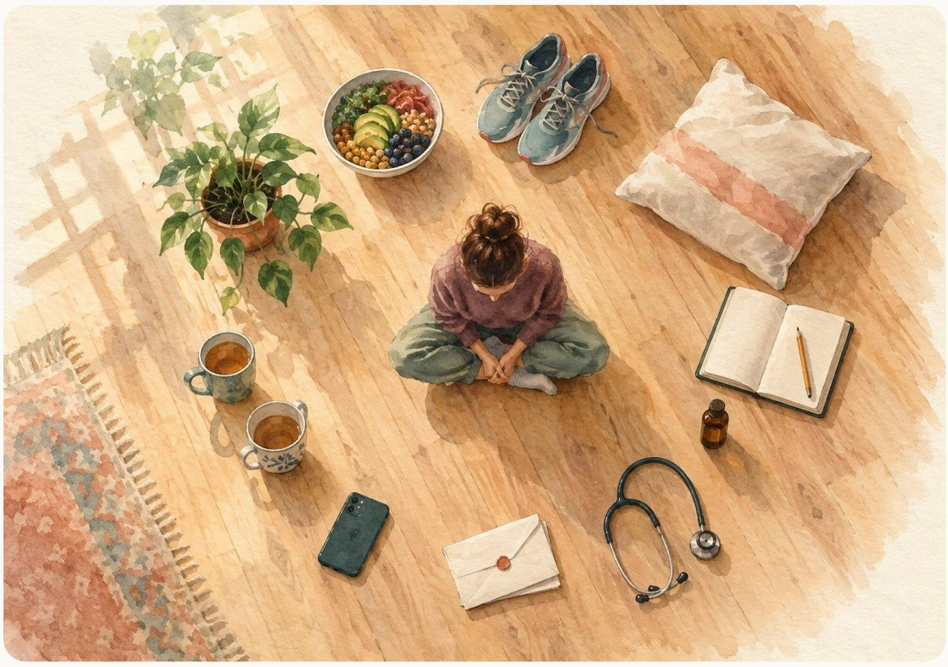
Three honest limits

A model can misread a table, blend two entries, or agree with you too easily. Ask it to cite the page, then check the page. Ask it what would change its answer. And never let it adjust a medication; that sentence is in this guide more than once on purpose.

In closing

Every part of you is in the room

You have just read a hundred entries about things that come in bottles. I want to leave you with the thing that does not.



When I sit down with someone who has IBD, I do not start with supplements. I start by taking a very detailed history, the way my pre-medical education and my training in neuroscience taught me to: the gastroenterologist, the medications and the last colonoscopy report; what is on the plate and when; how they sleep, and whether they wake rested; how they move, and whether they enjoy it. Then the parts a chart rarely holds: their relationships, the work they do and what it asks of them, the environment they live in, what happened in the year before the diagnosis, who is in their corner. Then, and only then, the herbs and the supplements. I call this systems-based health coaching, and the idea underneath it is simple: the gut wall you have read about does not know which of these things is acting on it. It only knows the sum.

That is why this guide kept saying "third." Not because supplements and herbs do not matter; I have watched them decide the difference between remission and a flare more times than I can count. But they work in proportion to the ground they stand on. The same phytosome curcumin can be almost nothing or almost everything, depending on what surrounds it: on top of six hours of sleep and a diet that is feeding the fire, a footnote; on top of a body that is fed, rested, moving and cared for by a team that knows what you take, the deciding force. Every aspect is part of the same system. You are allowed to work on all of it.

I also want to say something about the "why." I have Crohn's disease. I was the teenager in the gastroenterologist's office who did not understand a word, and the young adult who took the medication and still never felt well. What changed my life was not one supplement. It was learning that my body was a system I could study, that the science was readable if I was patient with it, and that my own experience, tracked honestly, was data too. This guide is my attempt to hand you that, faster than I found it.

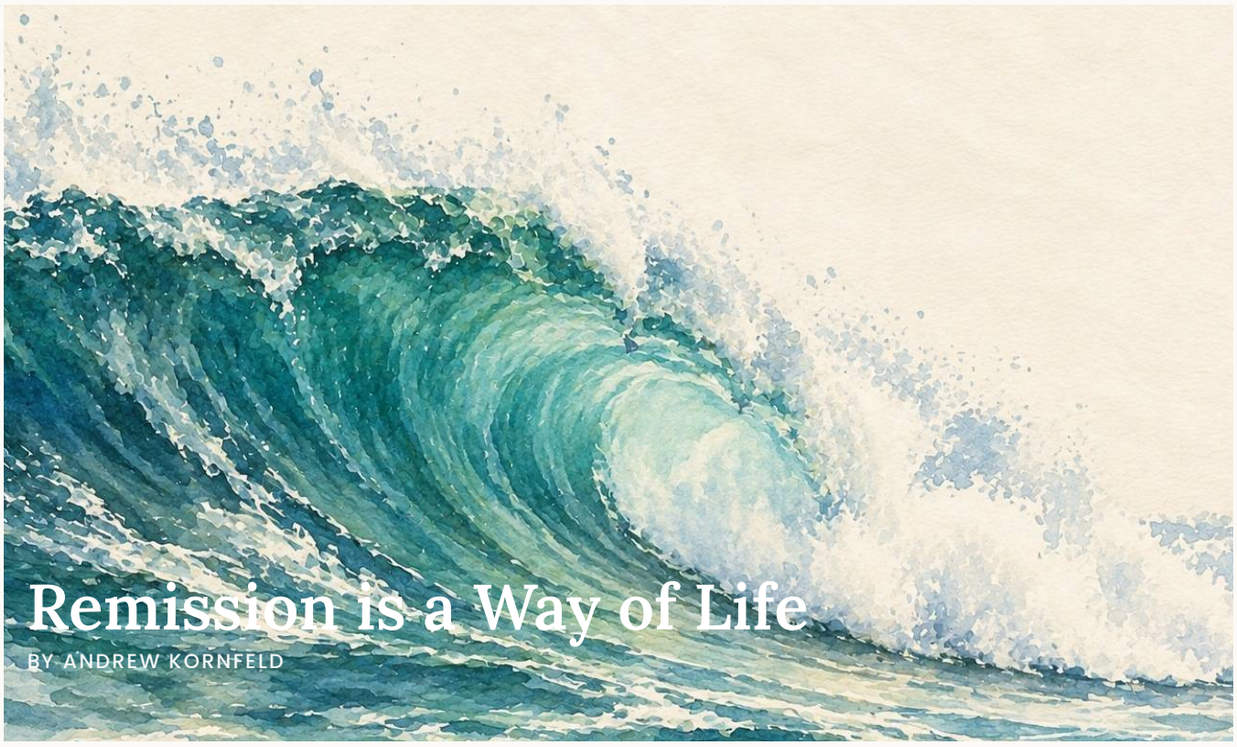
So here is what I hope you do next. Take the tracking sheet to your gastroenterologist. Pick one thing from the Five and give it a fair trial on a stable foundation. Protect your sleep like a prescription, because it is. Move, outside if you can. Eat in a way that your gut, not the internet, tells you is right. And when a bottle earns its place, buy the right one, at the right dose, and notice honestly what it does.

One more thing. We are in the age of AI, and I have given you a page on using it well. Human connection cannot be overstated: people who understand what you are living with, and are further down the road, will do things for your health that no model and no bottle can. Find them.

Then teach someone else. This guide is free and meant to be shared; the newest version will always be at **supplementsforibd.com**. If it helped you, share it with a friend or family member with IBD. If you found a mistake, tell me at **help@supplementsforibd.com**. And if you want a hand putting all of this together, that is what Systema is for.

Remission is not a place you arrive. It is a way you live. I wrote the next page about that, years ago, on a day I needed to read it myself. It is yours now.

With everything I have, Andrew



Remission is a Way of Life

BY ANDREW KORNFELD

Remission from Inflammatory Bowel Disease is not a destination; *it is a way of life.* You will not simply arrive there. You will ***live and breathe* remission every day.** Remission requires planning and awareness; strength and grit; a pronounced ability to adapt within new and challenging contexts and circumstances. **Remission is like surfing down the face of a wave**: a **state of flow** with your natural surroundings, where harmonious freedom meets refreshing control, **no longer resisting or fighting nature's power, but instead harnessing her energy for your mutual, symbiotic benefit.**

Achieving remission from IBD does not require magic. It instead demands remarkable **persistence** and **a new state of mind.** This change will allow you to engage reasonable strategies **based on scientific discovery and evidence.** You will begin to reconcile and observe the delicate **interconnection of human biology to the environment you inhabit.** You will acknowledge **yourself as an individual with unique life circumstances, needs, and dreams**, who will always require **tailored interventions designed specifically for you and *by you.***

You will learn that your condition gives you superpowers: as someone with IBD you have **extraordinary and rare abilities, allowing you to sense the makeup of your environment** and to **differentiate between what heals or harms you** with a newfound precision. With your newly realized superpowers you will **iterate continuously** and make changes to your life that bestow robust states of healing and health into the very core of **who you are.**

Embarking on the road to remission takes time and the process is non-linear. You will encounter obstacles that you could not predict nor prevent; *however*, you **must never give up or give in.** I can promise your health does not sleep and healing will not spontaneously arrive on your doorstep. Instead **you will intentionally harness the tools, the community, and the mindset to become a person who is stronger, happier, and more adaptable than ever before.** At this time **remission will cease to be a far-off, unattainable destination...**

it will become your way of life.

Back matter

Glossary

The words this guide uses without stopping to define them, in one place. The cytokines have their own spread in Section B.

Anthocyanins
The purple-blue pigments of bilberries, blueberries and pomegranate; polyphenols with anti-inflammatory activity in the gut (C-01).

Biologic
A medication made from a living system, usually an antibody, that blocks one specific immune signal: anti-TNF drugs, ustekinumab, vedolizumab and others.

BDNF
Brain-derived neurotrophic factor, the growth factor that lets neurons form and strengthen connections; rises with sleep, movement and learning, falls under chronic inflammation and stress (Section M).

Bioavailability
How much of a swallowed dose actually reaches the bloodstream or the target tissue. For curcumin, butyrate and the peptides, the form decides it.

Butyrate
A short-chain fatty acid made when gut bacteria ferment fiber; the colonocyte's preferred fuel and an epigenetic signal (F-02).

Calprotectin (fecal)
A protein released by neutrophils in the gut; measured in stool as a non-invasive marker of intestinal inflammation.

Colloidal dispersion
An ingredient milled into very small particles and kept suspended in liquid; the Theracurmin form of curcumin (Section K, drawn).

Colonocyte
The epithelial cell lining the colon. Runs on butyrate.

CRP
C-reactive protein, a blood marker of systemic inflammation driven largely by IL-6.

Cytokine
A small signaling protein immune cells use to talk to each other; TNF-α, IL-6 and the interleukins are cytokines.

Demulcent
A mucilage-rich botanical that coats and soothes a mucous membrane: slippery elm, marshmallow root, aloe inner leaf.

Dysbiosis
A microbiome that has lost the species that keep it calm and gained the ones that provoke.

Enterocyte
The absorptive epithelial cell of the small intestine. Runs on glutamine.

Enteric coating
A coating that keeps a capsule intact through the stomach so it opens in the intestine; essential for peppermint oil, the whole problem for butyrate.

Epithelium
The single layer of cells that lines the gut and stands between you and everything you swallow.

Evidence score
This guide's 1 to 5 scale for human IBD data specifically. Defined in "How to read this guide."

Excipient
An inactive ingredient: binder, filler, flow agent, coating. Section K is about which ones matter.

Goblet cell
The epithelial cell that makes and secretes mucus.

Incidence
The number of new diagnoses over a period of time, usually per 100,000 people per year. Compare prevalence.

Immunomodulator
A medication that damps the immune system broadly: thiopurines (azathioprine, mercaptopurine), methotrexate.

JAK inhibitor
A small-molecule drug that blocks the signaling many cytokines share: tofacitinib, upadacitinib.

Lamina propria
The connective-tissue layer beneath the epithelium where the gut's immune cells live.

Liposomal
Active ingredient enclosed in a phospholipid vesicle to protect it through digestion; quality varies widely (Section K, drawn).

Medical food
A US regulatory category for a food formulated for the dietary management of a condition under medical supervision; not an approved drug. EnteraGam, the prescription form of bovine immunoglobulins, is one (A-04).

Mesalamine (5-ASA)
The mainstay anti-inflammatory of ulcerative colitis, acting locally on the gut lining.

Microbiome
The trillions of bacteria, fungi and viruses living in the gut, and their genes.

Mucus layer
The gel above the epithelium, built from mucins and phosphatidylcholine; thinned in UC.

NF-κB
The transcription factor that switches inflammatory genes on; the master switch most polyphenols act on.

Nrf2
The transcription factor that switches the cell's antioxidant and repair machinery on.

Open-label
A study in which everyone knows who got the treatment; weaker than a blinded trial, and common in supplement research.

PepT1
A transporter in the membrane of gut-lining cells whose everyday job is to carry very small protein fragments from digested food into the cell; inflamed colon cells make far more of it, and KPV enters through it (Section G).

Peptide
A short chain of amino acids; BPC-157 has fifteen, KPV three.

Phenotype
How a disease shows up in a particular person: location, behavior, severity. Section N maps entries to it.

Phytosome
A plant compound bound to a phospholipid to carry it across the gut wall: Meriva (curcumin), Casperome (boswellia).

Polyphenol
A large family of plant compounds, curcumin, quercetin, resveratrol and EGCG among them, with antioxidant and signaling effects.

Prevalence
The number of people living with a disease at a given time, usually per 100,000; in IBD it keeps rising for decades after new diagnoses level off, because people live with the disease for a lifetime (front matter).

Prebiotic
A fiber or compound that feeds beneficial gut bacteria.

Probiotic
Live organisms taken for a health effect. Strain-specific; "probiotic" alone tells you little.

RCT
Randomized controlled trial; the strongest single study design, and the basis of a 4 or 5 on the evidence scale.

Remission
Disease that is quiet by symptoms (clinical), by scope (endoscopic) or by biopsy (histologic). They are not the same thing.

Repletion
Restoring a nutrient the disease has drained, guided by a lab test rather than a trial.

Skeletal formula
The compact way chemists draw a molecule: unlabeled corners and line ends are carbon, hydrogens on carbon are left out, other atoms are lettered, and lines are bonds (Section B, "A little biology").

Stable ID
The letter-number tag every entry carries, C-08 for example, that never changes between editions.

Thiopurine
Azathioprine or mercaptopurine; immunomodulators cleared by an enzyme (TPMT) worth testing before starting.

Tight junction
The protein seal between neighboring epithelial cells; when it opens, the wall leaks.

Th1 / Th17
Programs a T cell can adopt; both drive the inflammation of IBD, steered by IL-12 and IL-23.



A personal note

Need help putting all of this together?

A hundred supplements is a lot. Even the five at the front of this guide raise real questions: which first, how much, alongside which medication, and what to do when something does not agree with you. I would love to help you answer them.

I have Crohn's disease. I have spent nine years working with people who have IBD on the practice of remission: diet, mindset, medication decisions made with your team, and the supplements and herbs in these pages. That work is what **Systema Health** is, and systems-based health coaching is the modality I built for it.

Systema often works with people with complex IBD whose current approaches have not brought the results they hoped for, including people whose disease has not responded well to typical medication. We work alongside their medical teams, never in place of them, and I do not promise an outcome; what I promise is a serious, systematic look at the whole picture.

If you want to talk it through, you can schedule a free analysis call with me. We will look at where you are, what you are taking, what your team has you on, and what a sane next step looks like. I will help you understand this guide and actually use it. No pressure and no pitch; I would simply love to help.

I will help you. Andrew

Schedule your free analysis call

systema.health/apply-now

Systema IBD
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Back matter

References

Numbered by entry, in the order the entries appear. Sources added for this edition (the letters, the primer, the thyroid note, the B12 note, the F. prausnitzii pipeline and the label checks) were checked in September 2026. Always verify your own facts, and write to help@supplementsforibd.com if you find an error.

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C-13 · CoQ10

4. Natural antioxidant substances improve oxidative stress and alleviate ulcerative colitis: a meta-analysis of randomized controlled trials. Sci Rep 2025. PMC12753649. (Includes a 2021 double-blind RCT of CoQ10 200 mg/day for 8 weeks in UC, n = 86.)

C-14 · Rutin

5. Polyphenols and the potential mechanisms of their therapeutic benefits against inflammatory bowel diseases. J Funct Foods 2022. doi:10.1016/j.jff.2022.105181 (ScienceDirect S1756464622002511).

C-15 · Sulforaphane

6. The role of dietary nutrients in inflammatory bowel disease. Front Immunol 2018;9:3183.

C-16 · Reishi

7. Dietary polyphenols ameliorate inflammatory bowel diseases: advances and future perspectives to maximize their nutraceutical applications. Phytochem Rev 2023. doi:10.1007/s11101-023-09866-z.

C-18 · Lion's mane

8. Tursi A, D'Avino A, Brandimarte G, et al. Enhancing oral 5-ASA effectiveness in mild-to-moderate ulcerative colitis through an H. erinaceus-based nutraceutical add-on multi-compound: the HERICIUM-UC two-arm multicentre retrospective study. Pharmaceutics 2024;16(9):1133.

C-22 · Milk thistle

9. Rastegarpanah M, Malekzadeh R, Vahedi H, et al. A randomized, double blinded, placebo-controlled clinical trial of silymarin in ulcerative colitis. Chin J Integr Med 2015;21(12):902–906. (80 patients in remission; 140 mg/day for six months; hemoglobin and ESR improved; 35 of 38 vs 21 of 32 remained in remission.)

D-01 · Akkermansia muciniphila

0. Depommier C, Everard A, Druart C, et al. Supplementation with Akkermansia muciniphila in overweight and obese human volunteers: a proof-of-concept exploratory study. Nat Med 2019;25(7):1096–1103. (Safety and tolerability of live and pasteurized A. muciniphila in humans.)
1. Akkermansia muciniphila: the state of the art, 18 years after its first discovery. Front Gastroenterol 2022. doi:10.3389/fgstr.2022.1024393.
2. Akkermansia muciniphila supplementation alters inflammatory profiles across diverse models of colitis. Sci Rep 2026. doi:10.1038/s41598-026-60105-9.
3. Strain-dependent efficacy of pasteurized Akkermansia muciniphila in alleviating colitis reveals AKK2645 restores immune and microbial homeostasis. 2025. PMC13455503.

D-02 · Saccharomyces boulardii

74. Guslandi M, Mezzi G, Sorghi M, Testoni PA. Saccharomyces boulardii in maintenance treatment of Crohn's disease. Dig Dis Sci 2000;45(7):1462–1464.
75. Bourreille A, Cadiot G, Le Dreau G, et al. Saccharomyces boulardii does not prevent relapse of Crohn's disease. Clin Gastroenterol Hepatol 2013;11(8):982–987.

D-04 · Multi-strain Lactobacillus / Bifidobacterium

76. Furrie E, Macfarlane S, Kennedy A, et al. Synbiotic therapy (Bifidobacterium longum/Synergy 1) initiates resolution of inflammation in patients with active ulcerative colitis: a randomised controlled pilot trial. Gut 2005;54(2):242–249. (Listed in the 2024 Applied Sciences systematic review of phytochemical and nutritional RCTs in IBD.)
77. Therapeutic effects of probiotics on ulcerative colitis: review with tables of single- and multi-strain trials. Front Microbiol 2023;14:1211271.

D-05 · Lactobacillus reuteri

78. Oliva S, Di Nardo G, Ferrari F, et al. Randomised clinical trial: the effectiveness of Lactobacillus reuteri ATCC 55730 rectal enema in children with active distal ulcerative colitis. Aliment Pharmacol Ther 2012;35(3):327–334. (n = 40; Mayo score 8.6 to 3.2 vs no change on placebo; mucosal IL-10 up, TNF-alpha down.)

D-06 · Lactobacillus plantarum 299v

79. Therapeutic effects of probiotics on ulcerative colitis. Front Microbiol 2023;14:1211271. (Strain-level table.)

D-07 · Psyllium

80. Fernández-Bañares F, Hinojosa J, Sánchez-Lombraña JL, et al. Randomized clinical trial of Plantago ovata seeds (dietary fiber) as compared with mesalamine in maintaining remission in ulcerative colitis. Spanish Group for the Study of Crohn's Disease and Ulcerative Colitis (GETECCU). Am J Gastroenterol 1999;94(2):427–433.
81. Are all dietary fibers equal for patients with inflammatory bowel disease? A systematic review of randomized controlled trials. Nutr Rev 2022. PMC8990763.

D-08 · Partially hydrolyzed guar gum

82. Are all dietary fibers equal for patients with inflammatory bowel disease? A systematic review of randomized controlled trials. Nutr Rev 2022. PMC8990763.

D-09 · Inulin / FOS

83. Casellas F, Borruel N, Torrejón A, et al. Oral oligofructose-enriched inulin supplementation in acute ulcerative colitis is well tolerated and associated with lowered faecal calprotectin. Aliment Pharmacol Ther 2007;25(9):1061–1067.
84. Prebiotics for induction and maintenance of remission in ulcerative colitis. Cochrane Database Syst Rev 2023;CD015084.

D-10 · Galacto-oligosaccharides (GOS)

85. Are all dietary fibers equal for patients with inflammatory bowel disease? A systematic review of randomized controlled trials. Nutr Rev 2022. PMC8990763.

D-11 · Resistant starch

86. Are all dietary fibers equal for patients with inflammatory bowel disease? A systematic review of randomized controlled trials. Nutr Rev 2022. PMC8990763.

D-13 · Acacia gum

87. Are all dietary fibers equal for patients with inflammatory bowel disease? A systematic review of randomized controlled trials. Nutr Rev 2022. PMC8990763.

E-01 · Berberine

88. Efficacy and safety of berberine plus 5-ASA for ulcerative colitis: a systematic review and meta-analysis. PLoS One

2024. PMC11379390. (10 RCTs, 952 patients; clinical efficacy RR 1.22.)

9. ClinicalTrials.gov NCT02365480. Berberine chloride in preventing colorectal cancer in patients with ulcerative colitis in remission (Moss AC, principal investigator). Registry entry and protocol.

E-02 · Oregano oil

0. Roberts CL, et al. Translocation of Crohn's disease Escherichia coli across M-cells: contrasting effects of soluble plant fibres and emulsifiers. Gut 2010;59(10):1331–1339. (Context: dietary antimicrobials and the AIEC hypothesis.)

E-04 · Wormwood (Artemisia)

1. Omer B, Krebs S, Omer H, Noor TO. Steroid-sparing effect of wormwood (Artemisia absinthium) in Crohn's disease: a double-blind placebo-controlled study. Phytomedicine 2007;14(2–3):87–95.
2. Krebs S, Omer TN, Omer B. Wormwood (Artemisia absinthium) suppresses tumour necrosis factor alpha and accelerates healing in patients with Crohn's disease: a controlled clinical trial. Phytomedicine 2010;17(5):305–309.
3. Rahimi R, Nikfar S, Abdollahi M. Induction of clinical response and remission of inflammatory bowel disease by use of herbal medicines: a meta-analysis. World J Gastroenterol 2013;19(34):5738–5749. (Two A. absinthium trials, n = 60; relative risk for clinical remission 27; summarized in the Drugs.com wormwood monograph.)

F-01 · L-glutamine

4. Benjamin J, Makharia G, Ahuja V, et al. Glutamine and whey protein improve intestinal permeability and morphology in patients with Crohn's disease: a randomized controlled trial. Dig Dis Sci 2012;57(4):1000–1012.
5. Den Hond E, Hiele M, Peeters M, Ghoos Y, Rutgeerts P. Effect of long-term oral glutamine supplements on small intestinal permeability in patients with Crohn's disease. JPEN J Parenter Enteral Nutr 1999;23(1):7–11. PMID 9888411.
6. Akobeng AK, et al. Glutamine for induction of remission in Crohn's disease. Cochrane Database Syst Rev (two small studies; insufficient evidence).
7. A systematic review and meta-analysis of clinical trials on the effects of glutamine supplementation on gut permeability in adults. Amino Acids 2024. PMID 39397201. (10 studies, 352 participants; no overall effect.)

F-02 · Butyrate

8. Sodium butyrate effectiveness in children and adolescents with newly diagnosed inflammatory bowel diseases: randomized placebo-controlled multicenter trial. Nutrients 2022. PMC9414716. (150 mg twice daily add-on, 12 weeks, n = 72 completing.)

F-03 · Creatine

9. Wallimann T, Hall CHT, Colgan SP, Glover LE. Creatine supplementation for patients with inflammatory bowel diseases: a scientific rationale for a clinical trial. Nutrients 2021;13(5):1429.
0. ClinicalTrials.gov NCT02463305. Therapeutic modulation of the intestinal creatine kinase system in IBD (University of Colorado; pilot RCT of creatine 21 g/day in UC). Status: withdrawn, 0 participants.

F-04 · Aloe vera (inner leaf)

1. Langmead L, Feakins RM, Goldthorpe S, et al. Randomized, double-blind, placebo-controlled trial of oral aloe vera gel for active ulcerative colitis. Aliment Pharmacol Ther 2004;19(7):739–747.
2. ClinicalTrials.gov NCT04753775. Randomized, double-blind, placebo-controlled trial of enema aloe vera gel in active ulcerative proctosigmoiditis (Ospedale Sandro Pertini, Rome). Registry entry.

F-05 · Zinc carnosine

103. Mahmood A, FitzGerald AJ, Marchbank T, et al. Zinc carnosine, a health food supplement that stabilises small bowel integrity and stimulates gut repair processes. Gut 2007;56(2):168–175. (Crossover trial, 10 volunteers: 37.5 mg twice daily prevented the threefold rise in gut permeability caused by indomethacin.)
104. Davison G, Marchbank T, March DS, Thatcher R, Playford RJ. Zinc carnosine works with bovine colostrum in truncating heavy exercise-induced increase in gut permeability in healthy volunteers. Am J Clin Nutr 2016;104(2):526–536.

F-06 · N-acetylglucosamine (NAG)

105. Salvatore S, Heuschkel R, Tomlin S, et al. A pilot study of N-acetyl glucosamine, a nutritional substrate for glycosaminoglycan synthesis, in paediatric chronic inflammatory bowel disease. Aliment Pharmacol Ther 2000;14(12):1567–1579. (8 of 12 children with treatment-resistant IBD improved; histology and glycosaminoglycan layer improved.)
106. N-acetylglucosamine for treatment of inflammatory bowel disease. Natural Medicine Journal 2021/2022 (open-label adult series, 6 g/day for four weeks; 30–65% reported symptom improvement).

F-07 · Bovine colostrum

107. Khan Z, Macdonald C, Wicks AC, et al. Use of the 'nutriceutical', bovine colostrum, for the treatment of distal colitis: results from an initial study. Aliment Pharmacol Ther 2002;16(11):1917–1922.
108. Colostrum therapy for human gastrointestinal health and disease. Nutrients 2021. PMC8228205.

F-08 · Phosphatidylcholine

109. Stremmel W, Merle U, Zahn A, Autschbach F, Hinz U, Ehehalt R. Retarded release phosphatidylcholine benefits patients with chronic active ulcerative colitis. Gut 2005;54(7):966–971.
110. Stremmel W, Braun A, Hanemann A, Ehehalt R, Autschbach F, Karner M. Delayed release phosphatidylcholine in chronic-active ulcerative colitis: a randomized, double-blinded, dose finding study. J Clin Gastroenterol 2010;44(5):e101–e107.
111. Stremmel W, Vural H, et al. Delayed-release phosphatidylcholine is effective for treatment of ulcerative colitis: a meta-analysis. Dig Dis 2021;39(5):508. (3 RCTs, 160 patients; remission OR 9.68.)
112. Modified-release phosphatidylcholine (LT-02) for ulcerative colitis: two double-blind, randomized, placebo-controlled trials. Clin Gastroenterol Hepatol 2023. PMID 37806372. (PCG-2 terminated for futility; 466 randomized; deep remission 13.5% placebo vs 14.2% and 9.7% on LT-02.)

F-09 · Collagen peptides

113. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664. (Protein and nutritional status in IBD.)

F-10 · Slippery elm

114. Langmead L, Dawson C, Hawkins C, Banna N, Loo S, Rampton DS. Antioxidant effects of herbal therapies used by patients with inflammatory bowel disease: an in vitro study. Aliment Pharmacol Ther 2002;16(2):197–205. (Slippery elm, tormentil, devil's claw and wei tong ning scavenged oxygen radicals in inflamed UC biopsies, comparable to 5-ASA.)

F-12 · DGL licorice

115. Langhorst J, Wulfert H, Lauche R, et al. Systematic review of complementary and alternative medicine treatments in inflammatory bowel diseases. J Crohns Colitis 2015;9(1):86–106.

F-13 · Chamomile

6. Langhorst J, Varnhagen I, Schneider SB, et al. Randomised clinical trial: a herbal preparation of myrrh, chamomile and coffee charcoal compared with mesalazine in maintaining remission in ulcerative colitis, a double-blind, double-dummy study. Aliment Pharmacol Ther 2013;38(5):490–500. (Abstract: BMC Complement Altern Med 2012;12(Suppl 1):O27.)
7. Langhorst J, Wulfert H, Lauche R, Klose P, Cramer H, Dobos GJ, Korzenik J. Systematic review of complementary and alternative medicine treatments in inflammatory bowel diseases. J Crohns Colitis 2015;9(1):86–106. (Best herbal evidence: Plantago ovata and curcumin in UC maintenance, wormwood in Crohn's.)

G-01 · BPC-157

8. Sikiric P, Seiwerth S, Skrtic A, et al. Stable gastric pentadecapeptide BPC 157 as a therapy and safety key: a special beneficial pleiotropic effect controlling and modulating angiogenesis and the NO-system. Pharmaceuticals 2025;18(6):928.
9. Multifunctionality and possible medical application of the BPC 157 peptide: literature and patent review. 2025. PMC11859134. (Not approved by FDA or other regulators; human data insufficient.)
0. Operation Supplement Safety (US Department of Defense). BPC-157: a prohibited peptide and an unapproved drug found in health and wellness products. 2024.
1. STAT News, 3 February 2026. BPC-157: the peptide with big claims and scant evidence. (Nearly all data from one Croatian group; UC enema trials by PLIVA in the 2000s never fully published; a 2015 oral safety trial's registry data were withdrawn before review.)

G-02 · KPV

2. Multifunctionality and possible medical application of the BPC 157 peptide: literature and patent review. 2025. PMC11859134. (Context on oral peptide regulation.)

H-01 · Peppermint oil (enteric-coated)

3. Alammar N, Wang L, Saberi B, et al. The impact of peppermint oil on the irritable bowel syndrome: a meta-analysis of the pooled clinical data. BMC Complement Altern Med 2019;19:21. (Enteric-coated peppermint oil vs placebo: global symptoms RR 2.39; NNT 3.)
4. Ingrosso MR, et al. Systematic review and meta-analysis: efficacy of peppermint oil in irritable bowel syndrome. Aliment Pharmacol Ther 2022. (10 RCTs, 1,030 patients; superior to placebo, more adverse events, very low quality of evidence.)
5. Khanna R, MacDonald JK, Levesque BG. Peppermint oil for the treatment of irritable bowel syndrome: a systematic review and meta-analysis. J Clin Gastroenterol 2014;48(6):505–512.

H-02 · Broad-spectrum digestive enzymes

6. Pancreatic involvement in inflammatory bowel disease: a review. 2018. PMC6135003. (Fecal-elastase study: exocrine pancreatic insufficiency in 14% of Crohn's and 22% of UC patients.)
7. Can IgG4 levels identify the ulcerative colitis subtype of inflammatory bowel disease? Cross-sectional study, 2016. PMC5051143. (Exocrine pancreatic insufficiency in 17.8% of 56 IBD patients; literature range 8–50%.)

H-03 · Papain (papaya enzyme)

8. Kane S, Goldberg MJ. Use of bromelain for mild ulcerative colitis. Ann Intern Med 2000;132(8):680.

H-04 · Bromelain

9. Kane S, Goldberg MJ. Use of bromelain for mild ulcerative colitis. Ann Intern Med 2000;132(8):680. (Two patients achieving clinical and endoscopic remission.)
130. Onken JE, et al. Bromelain treatment decreases secretion of pro-inflammatory cytokines and chemokines by colon biopsies in vitro. Clin Immunol 2008. PMID 18160345.
131. ClinicalTrials.gov NCT06351696. The effects of bromelain supplement in patients with ulcerative colitis (Shahid Beheshti University; recruiting).

H-07 · Diamine oxidase (DAO)

132. Schnedl WJ, et al. Diamine oxidase supplementation improves symptoms in patients with histamine intolerance. Food Sci Biotechnol 2019;28(6):1779–1784.

I-01 · Tryptophan

133. Nikolaus S, Schulte B, Al-Massad N, et al. Increased tryptophan metabolism is associated with activity of inflammatory bowel diseases. Gastroenterology 2017;153(6):1504–1516.e2. (535 IBD patients; serum tryptophan lower and inversely correlated with disease activity.)
134. Agus A, Planchais J, Sokol H. Gut microbiota regulation of tryptophan metabolism in health and disease. Cell Host Microbe 2018; and Microbial tryptophan catabolites in health and disease, Nat Commun 2018;9:3294.

J-01 · Iron

135. Dignass AU, Gasche C, Bettenworth D, et al.; European Crohn's and Colitis Organisation. European consensus on the diagnosis and management of iron deficiency and anaemia in inflammatory bowel diseases. J Crohns Colitis 2015;9(3):211–222. (Screen every 3 months in active disease, 6–12 in remission; ferritin cut-offs 30 and 100 µg/L; intravenous iron first-line in active disease, oral intolerance, or Hb below 10 g/dL.)
136. Gasche C, Berstad A, Befrits R, et al. Guidelines on the diagnosis and management of iron deficiency and anemia in inflammatory bowel diseases. Inflamm Bowel Dis 2007;13(12):1545–1553.
137. Safety and efficacy of ferric carboxymaltose for iron deficiency anemia in inflammatory bowel disease: a systematic review. 2025. PMC11743820. (Up to 90% of oral iron is unabsorbed and can oxidize in the gut.)

J-02 · Vitamin B12

138. Scholten AM, et al. Surplus vitamin B12 use does not reduce fatigue in patients with irritable bowel syndrome or inflammatory bowel disease: a randomized double-blind placebo-controlled trial. Clin Nutr ESPEN 2018 (listed in a 2025 integrative review of pharmacological treatments for IBD fatigue).

J-03 · Folate (B9)

139. Antioxidant and anti-inflammatory phytochemicals for the treatment of inflammatory bowel disease: a systematic review. Appl Sci 2024;14(5):2177. (Table of RCTs 1993–2021 in IBD.)

J-04 · Zinc

140. Siva S, Rubin DT, Gulotta G, Wroblewski K, Pekow J. Zinc deficiency is associated with poor clinical outcomes in patients with inflammatory bowel disease. Inflamm Bowel Dis 2017;23(1):152–157. (More hospitalizations, surgeries and complications; normalization improved outcomes.)
141. Almuhaya H, et al. Prevalence and impact of zinc deficiency on clinical outcomes in inflammatory bowel disease. Nutrients 2025;17(21):3378. (45.6% of 447 patients deficient.)

J-05 · Magnesium

142. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664.

J-06 · Vitamin A

143. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664.

J-07 · Calcium

4. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664.

J-08 · Thiamine (B1)

5. Bager P, Hvas CL, Rud CL, Dahlerup JF. Randomised clinical trial: high-dose oral thiamine versus placebo for chronic fatigue in patients with quiescent inflammatory bowel disease. Aliment Pharmacol Ther 2021;53(1):79–86.
6. Bager P, et al. Long-term maintenance treatment with 300 mg thiamine for fatigue in patients with IBD: results from an open-label extension. 2022. (300 mg/day did not maintain the effect.)
7. Costantini A, Pala MI. Thiamine and fatigue in inflammatory bowel diseases: an open-label pilot study. J Altern Complement Med 2013;19(8):704–708.

J-09 · Riboflavin (B2)

8. von Martels JZH, Bourgonje AR, Klaassen MAY, et al. Riboflavin supplementation in patients with Crohn's disease (the RISE-UP study). J Crohns Colitis 2020. (Cited in Nutrients 2023 micronutrient review.)

J-10 · Niacin (B3)

9. Wallimann T, Hall CHT, Colgan SP, Glover LE. Creatine supplementation for patients with inflammatory bowel diseases. Nutrients 2021;13(5):1429. (Discussion of epithelial energy metabolism and GPR109A/butyrate signaling context.)

J-11 · Selenium

0. Natural antioxidant substances improve oxidative stress and alleviate ulcerative colitis: a meta-analysis of randomized controlled trials. Sci Rep 2025. PMC12753649. (Includes selenium trials.)

J-12 · Vitamin C

1. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664.

J-13 · Vitamin E

2. Mirbagheri SA, Nezami BG, Assa S, Hajimahmoodi M. Rectal administration of d-alpha tocopherol for active ulcerative colitis: a preliminary report. World J Gastroenterol 2008;14(39):5990–5995. (Open-label, 15 patients, 8,000 U/day enema for 12 weeks; Mayo DAI fell from 8 to 2.3; remission in 64%.)

J-14 · Vitamin B6

3. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664.

J-15 · Vitamin K2

4. Nakajima S, Iijima H, Egawa S, et al. Association of vitamin K deficiency with bone metabolism and clinical disease activity in inflammatory bowel disease. Nutrition 2011;27(10):1023–1028.

Visbiome / VSL#3 (closing table)

5. Sood A, Midha V, Makharia GK, et al. The probiotic preparation, VSL#3 induces remission in patients with mild-to-moderately active ulcerative colitis. Clin Gastroenterol Hepatol 2009;7(11):1202–1209. (n = 147; 32.5% vs 10% reached a 50% UCDAI reduction at 6 weeks.)
6. Tursi A, Brandimarte G, Papa A, et al. Treatment of relapsing mild-to-moderate ulcerative colitis with the probiotic VSL#3 as adjunctive to a standard pharmaceutical treatment: a double-blind, randomized, placebo-controlled study. Am J Gastroenterol 2010;105(10):2218–2227. (n = 144.)

Tormentil (closing table)

157. Langmead L, Dawson C, Hawkins C, Banna N, Loo S, Rampton DS. Antioxidant effects of herbal therapies used by patients with inflammatory bowel disease: an in vitro study. Aliment Pharmacol Ther 2002;16(2):197–205. (Tormentil among the herbs tested.)
158. Huber R, Ditfurth AV, Amann F, et al. Tormentil for active ulcerative colitis: an open-label, dose-escalating study. J Clin Gastroenterol 2007;41(9):834–838. (16 patients; CAI fell from 8 to 4.5 at 2,400 mg/day; tannins not detected in serum.)

Fecal microbiota transplantation (honorable mentions)

159. Březina J, Bajer L, Wohl P, et al. Fecal microbial transplantation versus mesalamine enema for treatment of active left-sided ulcerative colitis: results of a randomized controlled trial. J Clin Med 2021;10(13):2753.

Pouchitis note

160. Refractory pouchitis improves after administration of the green tea polyphenol EGCG: a retrospective review. Int J Colorectal Dis 2017.

J-00 · J-00

161. Nutrition, nutritional status, micronutrients deficiency, and disease course of inflammatory bowel disease. Nutrients 2023. PMC10489664. (Review of micronutrient deficiencies in IBD.)

Additives spotlight: emulsifiers, titanium dioxide, maltodextrin, carrageenan

162. Chassaing B, Koren O, Goodrich JK, et al. Dietary emulsifiers impact the mouse gut microbiota promoting colitis and metabolic syndrome. Nature 2015;519(7541):92–96. (Carboxymethylcellulose and polysorbate-80 at 1% in drinking water.)
163. Chassaing B, Van de Wiele T, De Bodt J, Marzorati M, Gewirtz AT. Dietary emulsifiers directly alter human microbiota composition and gene expression ex vivo potentiating intestinal inflammation. Gut 2017;66(8):1414–1427.
164. Chassaing B, Compher C, Bonhomme B, et al. Randomized controlled-feeding study of dietary emulsifier carboxymethylcellulose reveals detrimental impacts on the gut microbiota and metabolome. Gastroenterology 2022;162(3):743–756.
165. The emulsifier carboxymethylcellulose induces more aggressive colitis in humanized mice with inflammatory bowel disease microbiota than polysorbate-80. Nutrients 2021. PMC8540676.
166. Roberts CL, et al. Translocation of Crohn's disease Escherichia coli across M-cells: contrasting effects of soluble plant fibres and emulsifiers. Gut 2010;59(10):1331–1339. (Polysorbate-80 increased E. coli translocation; cited in the Nutrients 2021 paper above.)
167. Ruiz PA, Morón B, Becker HM, et al. Titanium dioxide nanoparticles exacerbate DSS-induced colitis: role of the NLRP3 inflammasome. Gut 2017;66(7):1216–1224. (Also found raised blood titanium in UC patients with active disease.)
168. Nickerson KP, McDonald C. Crohn's disease-associated adherent-invasive Escherichia coli adhesion is enhanced by exposure to the ubiquitous dietary polysaccharide maltodextrin. PLoS One 2012;7(12):e52132.
169. Bhattacharyya S, Shumard T, Xie H, et al. A randomized trial of the effects of the no-carrageenan diet on ulcerative colitis disease activity. Nutr Healthy Aging 2017;4(2):181–192. (12 patients in remission; 3 of 5 given carrageenan relapsed vs 0 of 7.)
170. Levine A, Rhodes JM, Lindsay JO, et al. Dietary guidance from the International Organization for the Study of Inflammatory Bowel Diseases. Clin Gastroenterol Hepatol 2020;18(6):1381–1392.

1. Laudisi F, Stolfi C, Monteleone G. Inflammatory bowel diseases and food additives: to add fuel on the flames! Nutrients 2019;11(5):1111.
2. Nickerson KP, Chanin R, McDonald C. Deregulation of intestinal anti-microbial defense by the dietary additive, maltodextrin. Gut Microbes 2015;6(1):78–83.

Four diseases, one guide (front matter)

3. Nguyen GC, Smalley WE, Vege SS, Carrasco-Labra A; Clinical Guidelines Committee. American Gastroenterological Association Institute guideline on the medical management of microscopic colitis. Gastroenterology 2016;150(1):242–246. (Budesonide first-line for induction and maintenance; budesonide over mesalamine, strong recommendation, high-quality evidence; suggests against probiotics for induction.)
4. Miehlke S, Guagnozzi D, Zabana Y, et al. European guidelines on microscopic colitis: United European Gastroenterology and European Microscopic Colitis Group statements and recommendations. United European Gastroenterol J 2021;9(1):13–37.
5. Kafil TS, et al. Interventions for treating collagenous colitis. Cochrane Database Syst Rev 2017;11:CD003575. (Twelve RCTs, 476 participants; Boswellia serrata clinical response 44% vs 27%, RR 1.64, 95% CI 0.60–4.49, GRADE low.)
6. Miehlke S, Verhaegh B, Tontini GE, Khalifa A, Heptner G, Villanacci V. Microscopic colitis: pathophysiology and clinical management. Lancet Gastroenterol Hepatol 2019;4(4):305–314.

A note on enemas, and the Briggs Protocol (Section L)

7. Briggs M. Understanding the pathogenesis of inflammatory bowel diseases, and moving towards a "functional cure." Self-published paper, 2017; summarized as the Briggs Protocol at thepowerofpoop.com/briggs-protocol. (Not peer-reviewed; a patient-scientist's synthesis of the barrier-translocation model with a three-phase supplement and enema plan.)
8. Oliva S, Di Nardo G, Ferrari F, et al. Randomised clinical trial: the effectiveness of Lactobacillus reuteri ATCC 55730 rectal enema in children with active distal ulcerative colitis. Aliment Pharmacol Ther 2012;35(3):327–334.
9. Khan Z, Macdonald C, Wicks AC, et al. Use of the 'nutriceutical', bovine colostrum, for the treatment of distal colitis: results from an initial study. Aliment Pharmacol Ther 2002;16(11):1917–1922.

Vitamin C before exercise (my personal protocol, Section N)

0. Ashton T, Young IS, Davison GW, et al. Exercise-induced endotoxemia: the effect of ascorbic acid supplementation. Free Radic Biol Med 2003;35(3):284–291. (Two weeks of 1,000 mg/day ascorbic acid blunted the rise in plasma endotoxin and lipid peroxidation after exhaustive exercise in healthy men.)
1. Gordon BL, Galati JS, Yang S, Longman RS, Lukin D, Scherl EJ, Battat R. Vitamin C deficiency in inflammatory bowel disease: the forgotten micronutrient. Crohns Colitis 360 2020;2(1):otaa008.

Why a gut guide has a brain section (Section M)

2. Bernstein CN, Singh S, Graff LA, Walker JR, Miller N, Cheang M. A prospective population-based study of triggers of symptomatic flares in IBD. Am J Gastroenterol 2010;105(9):1994–2002. (Perceived stress and negative affect predicted symptomatic flares over three months.)
3. Ananthakrishnan AN, Long MD, Martin CF, Sandler RS, Kappelman MD. Sleep disturbance and risk of active disease in patients with Crohn's disease and ulcerative colitis. Clin Gastroenterol Hepatol 2013;11(8):965–971. (Sleep disturbance in quiescent Crohn's disease roughly doubled the odds of active disease at six months.)
184. Felger JC, Treadway MT. Inflammation effects on motivation and motor activity: role of dopamine. Neuropsychopharmacology 2017;42(1):216–241.
185. Nielsen PR, Benros ME, Dalsgaard S. Associations between autoimmune diseases and attention-deficit/hyperactivity disorder: a nationwide study. J Am Acad Child Adolesc Psychiatry 2017;56(3):234–240.e1.
186. Irwin MR. Sleep and inflammation: partners in sickness and in health. Nat Rev Immunol 2019;19(11):702–715.

M-01 · M-01

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Back matter

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Clinicians and writers reference this document. Here is the form, and the stable IDs make any single entry citable on its own.

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