Managing LARS Symptoms

A self-study of the unfortunate, but strong-willed.

By Chris Avina

Foreword

First, if you are reading this document, it means you or a loved one has been diagnosed with colorectal cancer. I am extremely sorry for this unfortunate event in your life's journey. This trial will be difficult at times, and it will evolve and change over time. It will one day be a distant memory, and I hope that this guide helps that day arrive a little sooner than later.

Introduction

How to use this guide

This guide is based on my personal experience recovering from stage 1 colorectal cancer. My rectum and a chunk of my sigmoid colon have been completely removed. I did not have radiation or chemotherapy. I had an ileostomy bag for 3 months. After this reversal, I dedicated the next year to trying various diets and foods along with my knowledge of engineering in order to reign the symptoms in. The process was extremely difficult and uncomfortable. However, I am now living with minimal symptoms that are very non-invasive.

This guide is meant to be used as a source of generalized ideas that are meant to be combined with your own intuition and experience. As each individual's microbiome and LARS experience is unique, it is incredibly difficult to find a strict "one-size-fits-all" plan to manage symptoms. Please keep in mind that I am not a doctor. This is not a diet nor a lifestyle plan. It is a guide to hopefully help you to be able to digest fiber again in a year or less based on my personal experience. There are some things in my diet that are unique to me, such as the fact that I am allergic to cow's milk. I cannot attest to symptoms of Cow's milk products and LARS. I can say that Goat and Sheep milk products such as various cheeses have been safe for me. Also note that gluten caused issues in digestion for me, but in forms such as soy sauce, it seems perfectly fine.

In the body of this paper, you will find some generalized information that I wrote in January 2025 when I first began to see success with this plan. The conclusion was written in November 2025 after I have now experienced great success and have been living a rather comfortable and normal life. Beyond the conclusion, I included some of my personal notes taken while writing this (Dec 2024-January 2025) and I included personal notes written in November 2025 for comparison.

Consult with your physician before making adjustments in your LARS management plan.

Understanding LARS

Recovery Overview

Recovering from colorectal surgery can be a difficult process for many people. Depending on the location of your resection, a patient may be back at work in two weeks with almost zero issues. However, for those that have the rectum and parts of the sigmoid colon removed life can become particularly difficult due to symptoms like frequency, incontinence and constipation. These symptoms are packaged together and given the label of Lower Anterior Resection Syndrome (LARS).

LARS & What to Really Expect

In my own recovery, the LARS symptoms were rather intense. My body would be completely fine in the day time and begin to use the restroom consistently throughout the evening, extending well into the night. Initially this could leave me with somewhere near 20 bowel movements in a 24-hour period. Speaking with other LARS patients, not everyone has the same experience with timing. Many patients' symptoms have large overlap, but the timing, frequency, and consistency may vary.

Main Symptoms

The main symptoms that will impact a patient's day to day life:

- Clustering
- Incontinence
- Constipation
- Frequency
- Cramping/Bloating
- Erectile Dysfunction
- Sleep Issues

Incontinence

Incontinence is one of the largest concerns for patients, and understandably so. An accident is extremely embarrassing and off putting to patients. It also creates anxiety and fear over leaving the house or not having quick access to a restroom.

Triggers/Causes:

- Too much soluble fiber increased too rapidly
- Too much insoluble fiber taken at any time
- Lack of sphincter muscle motor recruitment

Constipation

Due to the newer narrow connection or lack of rectum, a patient's stool will often not bulk enough naturally before it has to evacuate. This can lead to patients feeling they need to use the restroom but cannot. Unfortunately, the lack of bulk in the stool only contributes and worsens this symptom. Without bulk, the stool can arrive at the end of the digestive cycle but not generate enough pressure to force evacuation, nor is the neuro-muscular connection rebuilt and strong enough to stimulate the bowel movement easily.

Triggers/Causes:

- Too little insoluble fiber throughout the day
- Too little soluble fiber throughout the day
- Too little water
- Too much Imodium

Clustering

Clustering is a combination of symptoms creating a unique symptom in itself. It is the most unfavorable symptom by far, but also seems to be the most common in patients. A patient clustering will have many frequent bowel movements over the course of a period of time. This can happen in batches throughout the day or night and be very exhausting. Clustering can happen due to either constipation or incontinence. In the beginning, it is likely a patient will swing between the two causes. Clustering from constipation tends to be worse as it has a longer duration and is more painful, but clustering from incontinence comes with a high risk of having an accident. Both symptoms generally have increased frequency or frequent urges that have patients trying to evacuate their bowels.

Many patients that have not found a balance between the two causes opt for using enemas or drink beverages such as prune juice to try to induce bowel movements to reduce clustering.

Triggers/Causes

- Constipation creating many frequent urges, but unable to evacuate enough to relieve in a timely fashion.
- Incontinence that creates many frequent movements, but unable to evacuate enough to relieve in a timely fashion.

Personally, based on the patterns I recognized in timings, I set a goal for myself of 2-3 controlled bowel movements a day.

The Fiber Paradox

Those who suffer from LARS suffer from the "Fiber Paradox". Patients' bodies cannot digest insoluble fiber without generating extreme symptoms such as incontinence and bloating. Unfortunately, they also need insoluble fiber in order to bulk stool and reduce clustering.

Types of Fiber

There are two types of fiber that impact LARS patients: soluble and insoluble. Soluble forms a gel-like substance in the gut and slows digestion, while insoluble adds bulk to the stool and speeds colonic transit (Mt. Sinai: (https://www.mountsinai.org/health-library/special-topic/soluble-vs-insoluble-fiber).

Soluble Fiber
Soluble Fiber is found in things like oats, beans, bananas, and psyllium. It is mainly used to bulk and help pass stool, alleviating constipation or diarrhea. Soluble fiber absorbs water and slows the digestive process down. This can help the body absorb nutrients and increase stool consistency. In turn, increasing stool consistency and bulk, can help reduce the number of bowel movements per day.

Insoluble Fiber
Insoluble fiber is found in many raw forms of veggies and fruits such as raw carrots, greens or blackberries. Insoluble fiber also helps to bulk stool, however, many patients are intolerant to it for some time. Insoluble fiber can slow digestion down, but can have the effect of increasing intestinal motility in some patients.

Dietary Fiber

Many packaged foods have a label of dietary fiber. This has been found to be insoluble fiber more often than not.

Fructans

Fructans are a special type of insoluble fiber. They are generally considered as prebiotics, but they also can wreak havoc on a patient's system. An example of high fructan foods are garlic and onion. They generally coincide with high FODMAP foods, and can cause extreme bloating and discomfort for a patient.

Personally, I stay away from high fructan foods. I have found that using things like garlic oil instead of actual garlic seems to be safe for me.

The Clustering Equation: Finding Balance

One way to conceptualize the Fiber Paradox is a balance between two opposing processes: digestion and intestinal motility. Managing symptoms becomes an exercise in finding equilibrium between speeding up and slowing down the digestive system to control timing and reduce clustering.

The Equation

A goal to improve patients' quality of life would be to minimize these symptoms as quickly as possible using diet and nutritional supplements

As clustering is the most intrusive, but also comprised of both constipation and incontinence, It is safe to assume that reducing constipation and incontinence will reduce not only minor symptoms such as bloating, but also clustering.

This might lead one to believe that there is a point that balances between the two that can relieve constipation enough but not instigate incontinence.

Using the Intermediate Value Theorem from Calculus, it can be assumed that if we have these two opposite extremes in a closed interval, there must be a balanced point such that the equation is equal to zero.

This leads to the derivation of a simple, but important equation for managing clustering symptoms.

Clustering Equation

Let:

- **C** = degree of constipation
- **I** = degree of incontinence
- **S** = overall symptom severity or quality-of-life impact

We assume that:

- Increasing constipation (C) worsens symptoms.

- Increasing incontinence (I) worsens symptoms.
- Reducing one too much can worsen the other, meaning there is a balance point between them.

Step 1 – Define the relationship

We describe symptom severity as a balance between two effects:

$$S(C, I) = f(C) - g(I)$$

where:

- *f(C)* measures the severity caused by constipation
- *g(I)* measures the severity caused by incontinence

Both *f(C)* and *g(I)* are continuous. They change smoothly as C or I changes.

Step 2 – Applying the Intermediate Value Theorem (IVT)

If there exists an interval [C_min, C_max] such that

$$S(C_{min}) > 0 \; and \; S(C_{max}) < 0,$$

then, by the Intermediate Value Theorem, there must be at least one point **c′** in that interval where

$$S(c') = 0$$

or equivalently

$$f(c') = g(I)$$

Step 3 – Interpretation

At **c′**, the negative effects of constipation and incontinence balance each other.
This represents the equilibrium point where overall symptom severity is minimized or most stable.

- When **C < c′**, constipation dominates (too slow).

- When **C > c′**, incontinence dominates (too fast).
- When **C = c′**, symptoms are balanced.

Finding Balance

An optimal solution for a patient would be to balance the Clustering Equation using an increased amount of fiber, both soluble and insoluble. The constraint for the patient is the ability to digest insoluble fiber without inducing bloating and incontinence. This constraint then becomes the determining factor in the balancing of the Clustering Equation

Controlling the intake of soluble fiber, insoluble fiber, and water should help improve clustering symptoms. Many patients find themselves unable to find a comfortable place due to bloating and issues caused by consuming insoluble fiber. Reintroducing sources of insoluble fiber is key to improving gut health and in turn, reducing clustering symptoms.

Based on the intuition derived from our equation, we need to consume some amount of soluble fiber, and insoluble fiber while consuming a high amount of water to balance the symptoms of constipation and incontinence.

Many doctors recommend a fiber supplement such as metamucil, but many patients find it to cause bloating and diarrhea. Many patients prefer to use psyllium husk as a source of soluble fiber.

Experimental Approach

Safety Note: Always increase fiber gradually to avoid intestinal blockages.
Consult your physician before beginning any fiber or Imodium regimen.

Introducing Psyllium Husk

Psyllium husk comes in the form of a powder. It can be mixed with water directly, or taken in capsules. The capsule form seemed to provide the most consistency in results.

The timing of psyllium husk intake has varied from patient to patient. Some consume it all in the morning, while others consume it only at night before bed. Others have found taking it prior to meals provides the best results.

I have found that psyllium husk capsules have provided the best results when taken 15-30 minutes prior to a meal with 10-20 oz of water before the meal.

Psyllium husk dosages need to be increased over time. If a patient takes a full dose and causes diarrhea or incontinence, it is likely that too much was taken too quickly for the patient's system to handle. In this case, the dosage should be reduced by a small amount and held steady for 2-3 days so the body can adjust. Once it is adjusted, increasing it by a small amount each day should provide little issues. It is important to consume high amounts of water and not over consume psyllium husk to avoid an intestinal blockage.

Increasing and establishing the psyllium husk dosage should be done without consuming insoluble fibers as the two will interact. This will likely be a little uncomfortable, but as the dosage increases, it should ease. Once the psyllium husk dosage is established, a patient will then introduce insoluble fibers.

Knowing if you have the right dose

The right dose of psyllium husk is the dose right before it causes diarrhea or incontinence. The stool should be bulked and not dry, but will very likely be small in comparison to stool before surgery. The size does not allow for enough pressure to build to be evacuated in the bowels. This will likely lead to a feeling of almost being constipated.

Stopping right before the feeling of constipation allows for introduction of insoluble fiber to complement the stool bulked from psyllium husk.

Example of finding my psyllium husk dosage

Through trial and error, I found that taking a 6-5-6 regimen with their respective meals was best for me. After going through the adjustment period for psyllium husk, I increased my dosage over time to 7-6-7. This proved to be far too much for my system and caused incontinence. From here, I continued to roll back a pill, one day at a time until it reached the point where if I increased it by 1 or 2 pills, I would have incontinence.

The timing and dosage will vary for each individual, and it is likely a patient can also adjust the dosages per meal to achieve bowel evacuations at approximate times.

Introducing Insoluble Fiber

For those who are sensitive, introducing insoluble fiber must also be done slowly over time. The easiest sources to introduce tend to be from fruits or from nuts such as kiwi, blueberries or walnuts.

Many patients find extreme difficulty with insoluble fiber. The gut is not prepared to break down and digest the fiber, creating incontinence and diarrhea.

Example of lettuces as a source of Insoluble Fiber

Personally, certain greens were ok for me while others were not. For example, chopped cabbage, arugula, and iceberg lettuces were all safe to eat consistently after I tuned my system with Imodium (see the section below). However, very leafy greens such as romaine or red leaf lettuces need to be consumed in smaller quantities, and depending on the day, maybe not at all.

All insoluble fibers should be added slowly until the body can digest it properly. This can be aided with digestive enzymes or tuning the body with Imodium if it's very extreme.

Digestive Enzymes

Many patients find that digestive enzymes taken before a meal help to digest foods. Some patients report that the digestive enzymes alone are enough, while others need further tuning with Imodium (loperamide).

Digestive enzymes were confirmed to help in my process as well.

Imodium

The two adverse side effects of introducing insoluble fiber are bloating and incontinence. Using Imodium (loperamide) and simethicone help relieve these side effects while introducing insoluble fiber over a short, planned “training” phase. Not only that, but the slowing of digestion and consumption of fiber helps to re-establish the gut micro-biome, allowing for further consumption of a wider range of foods in the future.

Imodium should be used to train a patient’s digestive system. It is not desired by many patients that they should have to consume Imodium the rest of their lives.

Using Imodium should only be done after (1) introducing digestive enzymes, (2) achieving the proper bulk with soluble fiber, and (3) determining that any amount of insoluble fiber causes incontinence or diarrhea, in that order.

A practical approach is to take Imodium with meals for 2-4 days while adding small amounts of insoluble fiber, allowing the gut more time to process.

It is expected that over the course of the 2-4 days, the patient will become constipated. Once that state has been achieved, the patient should stop taking Imodium for 1-2 days to allow a full

digestive cycle to process, continuing to consume small amounts of the same insoluble fiber as tolerated.

Repeating this cycle twice over two weeks was sufficient in my case to restore substantial tolerance.

Results & Discussion

Bulking the Stool

Personal notes on: Bulking The Stool - January 2025

Fiber Supplement

Many people choose between Psyllium Husk or Metamucil. I tried Metamucil for an extended period of time and it always created loose bowel movements. I switched to Psyllium Husk powder and mixed it with water. It gave better results, but it was inconsistent. I switched to 500 mg capsules and had consistent results. I have continued using the capsules.

In order to find the correct dosage, I increased the amount over the course of a series of days until I would get loose stool. I would continue the dosage for one more day to ensure my body could not adjust to it. If I could not adjust, I rolled the dosage back one until I had solid stool again.

It is important to note that the bulk I achieved here was rather minimal. It was just enough to keep me from being incontinent, but it was not easy to go due to its small bulk. I would still experience bouts of clustering in this first iteration of this phase.

I also noted that eating very large quantities of food provided substantial bulking. However, it was unrealistic to consume ~1100 calories of whole foods at every meal.

I also noted that flat rice noodles such as those that come in the Thai dish, Pad See Eiw, provide the best, most consistent bulk out of any food I tried.

Example:

I slowly increased the amount I was taking from 2 capsules per meal to 3 capsules per meal over the course of a day. The next day, I increased to 4 capsules per meal, but it instigated a bowel movement that I can only describe as “you can tell you had too much fiber” loose. I would

continue the 4 for one more day to see if it would stabilize. If it did not, then I rolled back one dose and stayed consistent with that.

In my first iteration of phase 1, I got up to three 500 mg capsules for each meal at max. Any more than that and I would experience incontinence.

Personal notes on: Bulking the Stool - November 2025

I currently and have been consistently taking 6 500 mg capsules with Breakfast, 5 with Lunch and 6 with Dinner. I did take digestive enzymes for some period of time. I have now stopped using them and feel no need for them. I stopped using them out of my own personal dislike of taking pills.

My stool is consistently bulked. I usually eat at least one small salad per day and I consistently eat veggies such as potato, sweet potato, zucchini and other root vegetables. Pho and bone broths seem to help greatly with bulking due to the collagen and rice noodles.

Increasing Fiber Intake

Personal notes on: Increasing My Fiber Intake - January 2025

Unfortunately, the only way to teach your gut to digest fiber is to eat more fiber. Eating fiber made me incontinent, so using Imodium at this stage seemed logical. However, my use case was to only slow my digestion down. I was not looking to treat my incontinence with Imodium. I wanted to take the Imodium so it would give my digestive process more time to handle the fiber I would ingest during that period. Simethicone was also a very helpful tool in this phase to manage gas and bloating.

As I had not used Imodium at all,I tried to take 1 Imodium with a low-fiber meal at the beginning of my digestive cycle in hopes of slowing the digestion down, allowing for more food to digest and bulk.

I saw positive results over the course of two days in the form of delayed bowel movement timing and bulk, but it became inconsistent and I wanted to do further exploration. I took a break for a week to let everything normalize to begin with a new regiment.

I began taking 1 Imodium per meal and switched to a completely higher fiber diet. I slowly introduced things that would normally cause incontinence such as oatmeal, pomegranate, nuts and greens during this phase. I incorporated some amount of insoluble fiber with every meal.

I eventually would become constipated over the course of 2-3 days. Once the constipation began, I stopped taking the Imodium for a few days to let my body reset. I continued eating the same high fiber foods during the reset period based upon my own intuition.

I repeated this cycle over the course of two weeks.

At the end of the two weeks I have been digesting fibrous foods such as raw leafy greens, kiwi, and pomegranate without Imodium and it has continued.

I still was unable to achieve the exact full bulk I needed by the end of this cycle. However, with my increased capacity for fiber, I revisited increasing my Psyllium Husk dosage a bit more using the same algorithm.

Personal note on: Increasing My Fiber Intake - November 2025

I have been consuming things such as bean sprouts, leafier lettuces, and even introducing legumes as of October 2025. Legumes have been very tricky, but I found that Gigante beans worked perfectly as I could get them ready to eat in small quantities from Whole Foods. I have been eating 1 bean with breakfast per day for about 3 weeks or so. I increased it to two beans and was fine with that for one day, but once I increased it to a series of two beans, two days in a row, it proved to be too much and I rolled back to 1 per day. I expect to be able to eat them more freely in another week or two.

Symptoms Progress

Personal notes on: Symptoms as of January 2025

As of writing this, I've only been out of Imodium training for two weeks. It has been very successful so far. Despite the success, there are still some hoops I have to jump through. I expect everyone will have their own.

Positive Changes:

1. No clustering.
2. No incontinence.
3. Fully bulked stool.
4. ~2 Bowel Movements in a 24-hour period.
5. Only 1 bowel movement at night vs 3 at minimum prior.

Personal notes on: Symptoms as of November 2025

I have not used Imodium since my initial cycle in January. I consistently eat fibrous foods, and have no problem eating the occasional burger.

Positive Changes:

1. No clustering, unless needed to skip a dose of psyllium husk to ensure I do not have to use the restroom to attend a social event. Skipping a dose gives me freedom to go about my day with a GUARANTEE of not even needing to use the restroom later in the day or event, but it comes at the cost of possible light clustering the next day. It's a trade-off I happily make, and I honestly am probably being overly cautious.

2. No incontinence.

3. My stool is fully bulked unless I skip a dose as I mentioned before. If I do not eat enough insoluble fiber, it will also not be as bulked. I ensure to eat a balanced, but high fiber diet.

4. Average 1 Bowel Movement in a 24-hour period

5. Sleep through the night on most nights.

6. Able to eat a much wider range of foods such as salad, broccoli, tacos, burgers, fries.

Meal Timing

Personal notes on: Meal timings - January 2025

Due to the timing of my digestive cycle and my desire to sleep, I have my first two meals of the day within 3 hours of each other. Dinner can be any time in the evening. This part is constantly changing and I am exploring different times.

Personal notes on: Meal timings - November 2025

I am no longer restricted to eating at specific times. I eat meals as I would prior to having been diagnosed, and I snack freely. I just need to ensure I take my psyllium husk with each meal.

Food & Diet Changes

Personal notes on: Food & Diet Changes - January 2025

I still avoid garlic, onion, gluten, and heavily fried foods. Those are now my only rules.

I have noticed the first time I ingest a new type of fibrous food it will usually stimulate an extra bowel movement or I might experience a little looser stool that day. I have not found anything that my body has rejected or expelled in the same fashion prior to completing the Imodium phase of this experiment.

Personal notes on: Food & Diet Changes - November 2025

I still avoid garlic, onion,and heavily fried foods. I started reintroducing gluten this past week and have had success. I think by next month I will be able to fully enjoy noodles again. Anything heavily fried or too greasy would still trigger loose stools, so it is avoided.

Garlic infused olive-oil has been very successful. I also have been fine eating blended salsas such as Salsa Verde and Salsa Roja. It seems that the smaller size of the garlic and onion allows my body to break it down easier.

Key Takeaways

Personal Key Notes - January 2025

- We need bulked stool to alleviate ourselves
- Insoluble fiber bulks stool, but we have a hard time digesting it
- Insoluble fiber speeds up the passing of stool in the intestines
- Soluble fiber slows down digestion
- Imodium slows down intestinal motility, which increases the time food spends in the digestive tract.

Using a combination of soluble fiber and insoluble fiber, we can find a balance between the symptoms of incontinence and constipation.

In order to teach our digestive systems to digest the needed insoluble fiber, we need to manage symptoms while it adjusts. Once a proper bulk has been achieved using soluble fiber and bulking foods, we can use Imodium to “throttle” the digestive process. We can use Imodium and Simethicone to manage symptoms for a short burst of time, while ingesting fiber in slowly increasing amounts. The extra digestive time from the Imodium will hopefully help the body learn to process and break down the fiber properly.

Personal Key Notes - November 2025

I stand by my previous key notes written in January 2025, and my ability to freely move about the world without anxiety or fear of an episode of clustering is a testament to those key points. I continue to be able to widen the variety of foods I eat while maintaining balance.

Conclusion

This paper was written through December 2024 and January 2025. I am writing this conclusion in November 2025 just before the 2 year mark of my ileostomy reversal (November 2023). I am happy to report great success in the experiment.

As of September 2025, I regularly eat salads, various fruits and vegetables and have even begun re-introducing legumes into my diet. The reintroduction of new insoluble fiber is still done very slowly to assure my comfort, but it has been working. I do not fear leaving my house any longer. I do not experience extreme bloating or incontinence, and I generally live a pretty normal life. I do have to make occasional choices about meal timing depending on my schedule for the day.

My continued improvement and the consistency of my results over time serve as practical proof that a balance point between constipation and incontinence, in the context of LARS, truly exists. According to the *Clustering Equation* and the *Intermediate Value Theorem*, if two opposing conditions are continuous and influence each other, there must exist a point of equilibrium between them. The balance point is not theoretical; it is observable, repeatable, and reversible. My progress stands as direct evidence that equilibrium between digestion rate and intestinal motility can be achieved.

When I deviate from this balance by skipping psyllium husk or eating high-fructan foods, symptoms regress temporarily. These regressions act as counter-proof, confirming the model: when I move away from equilibrium, imbalance returns.

Appendices

Appendix A - Sample Meals (Pre-Imodium Phase, November 2024)

Sample diet prior to Imodium training - November 2024

Wake up:
Hot water
Tea/Black Coffee

Breakfast:
Athletic Greens
3 Psyllium Husk Capsules 500 mg
2 Digestive Enzymes
2 eggs
3 sausages
1 oz feta
1 oz sauerkraut
2 pieces of gluten free toast
½ avocado

Lunch:
3 Psyllium Husk Capsules 500 mg
2 Digestive Enzymes
White Rice
Zucchini
Tofu/Chicken
Banana

Dinner:
3 Psyllium Husk Capsules 500 mg
2 Digestive Enzymes
White Rice
Zucchini
Tofu/Chicken

Appendix B - Sample Meals (Post-Imodium Phase, January 2025)

Sample diet post Imodium training - January 2025

Wake up:
Hot water
Tea/Black Coffee

Breakfast:
5 Psyllium Husk Capsules 500 mg
2 Digestive Enzymes
Athletic Greens

Overnight Oats:
½ cup Oats
¾ cup almond milk
1 Tbsp Chia Seeds
Walnuts
Pomegranate
Blueberries
Honey

2 eggs
1.5 cups of sauteed greens
3 chicken sausages

Lunch:
5 Psyllium Husk Capsules 500 mg
2 Digestive Enzymes
Mixed Greens
Feta
Chicken Breast
Cucumber
Dill

Mid-Day:
Espresso

Dinner:
5 Psyllium Husk Capsules 500 mg
2 Digestive Enzymes
Tofu Stir Fry w/
Rice
Sugar Snap Peas

Carrots
Ginger
Green Onion
Bell Pepper

Appendix C - Sample Meals (Maintenance Phase, November 2025)

Sample Meals- November 2025

Athletic Greens
Black Coffee

Breakfast:
6 Psyllium Husk Capsules 500 mg

2-3 Eggs
Potatoes
Zucchini
Tomato or other vegetable to scramble in
Feta (Goat)
Olives

Lunch:
5 Psyllium Husk Capsules 500 mg
Large salad:
Arugula
Shredded Cabbage
Almonds
Chicken
Carrots
Cilantro
Wild Rice

Dinner:
6 Psyllium Husk Capsules 500 mg
Rummo Gluten-Free Spaghetti noodles
Sauce:
5 Tbsp Garlic Oil
Carrot
Zucchini
Mushrooms
Basil
1 Can San Marzano Tomatoes

10-12 Basil leaves
Feta Cheese (Goat)

Snacks:
Banana
Avocado
Siete Brand Chips
Epic Venison Bars
Potato Salad
Coleslaw
Coconut Yogurt
Goat Cheeses
Gluten Free Crackers
Rice Cakes
Kimchi

Other foods marked safe and can be swapped in for any meal - November 2025

Tacos (Corn tortillas, Carne Asada/Chicken only!)
Sandwiches on Gluten-free bread
Grilled Chik-Fil-A sandwich on gluten free Bun
Burgers/Fries from a solid burger place on a gluten free bun or lettuce wrapped (No McDonalds)
Pho
Any dishes with rice noodles and no garlic/onion.
Teriyaki
Ribs
Steak
Broccolini
Broccoli
Olives
Bacon