



Your Functional Medicine Expert®  
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[#97: Dr. Jill interviews Brie Wieselmann, LAc, MTM on IBS Beyond SIBO](#)

Dr. Jill 0:12

Hello everybody! It's Dr. Jill with Dr. Jill Live today. I'm so excited to have a new guest and a new friend today. We haven't known each other that long, but I have great respect for what she's doing, and it's so parallel to all of us in functional medicine with the gut. I hope you're really excited today because I know a ton of you struggle with gut issues. Today we're going to dive into some of the reasons why, if you've been diagnosed with IBS or SIBO, you haven't been able to overcome it. I know Brie will enlighten us with some of her expertise, and I'm excited about our conversation.

Dr. Jill 0:42

A little background. If you haven't seen our other episodes, we're out into the 90s now, and you can find them all on YouTube on my channel, which is just under my name. If you need any resources, I also have 10+ years' [worth] of weekly articles that are all available for free at [jillcarnahan.com](http://jillcarnahan.com), and products and services you can find at [drjillhealth.com](http://drjillhealth.com).

Dr. Jill 1:02

I want to introduce my guest today. I'm super excited to have Brie Wieselmann here. She's a licensed acupuncturist and medical director of Brie Wieselmann Integrative Health. It sounds like you have other practitioners, which I'd love to ask you about when we get into how your clinic is run. Over the past 14 years, she and her team have empowered men and women with transformations in health. She has been an expert in hormone balance and fertility, which again, I'd love to maybe delve into that just a little because it can have relation to the gut, right? She especially specializes in healing digestive problems such as IBS, ulcerative colitis, parasitic infections, candida, and SIBO. I love what she talks about in her bio, rebuilding a bulletproof microbiome, and that's where we're going to go today because, again, a lot of the stuff on SIBO is great, but often—right, Brie?—there are so many other things that can go wrong. If you just look at SIBO, there are deeper reasons, and we'll dive into all that today.

Dr. Jill 1:54

Prior to starting your clinic or founding your clinic, she spent several years specializing in the treatment of fertility and subfertility at several IVF centers in the San Francisco Bay area, and her local clinic specializes in the integrative treatment of hepatitis C, so that's awesome—some of those chronic, tough viral things. She speaks and teaches all over. She's a guest on frequent podcasts. She's done much education similar to me. She did some work through the Kalish Institute and the Institute for Functional Medicine. I am absolutely delighted to have you here, Brie. Thanks for joining me!

Brie Wieselmann 2:27

Oh, thanks for having me. I'm thrilled to be here with you!

Dr. Jill 2:29

I always love to start [with a] story as far as how you got into functional integrative medicine—your journey. Tell us just a little bit about how that looks. Did you always want to go into some kind of healing profession, or how did that look for you?—your journey.

Brie Wieselmann 2:44

Yes. Like many of us, I had my own health challenges and then wound up finding myself, seeking answers, and putting together the pieces of the storyline. So I think I always knew I wanted to be some kind of helping professional, but I don't think I landed on medicine until a bit later. The medicine piece [was] partially influenced by my backstory. I had severe asthma as a kid, and I had some eating disorders as a teen that translated later into my version of veganism, which wasn't, candidly, very nutritionally complete. There are a lot of great ways to do that if you want to, but I wasn't doing it. I really didn't have the education.

Brie Wieselmann 3:28

I diagnosed myself as having polycystic ovarian syndrome. At the time that I was figuring that out, it wasn't widely known unless you had a textbook case. So I figured out, like, "Okay, why do I have all these irregular periods and acne that I didn't have as a teen, but now I have as a young adult?"—and a bunch of things like that. Also, [I had] this predisposition, frankly, when I was out of balance to run anxious or have panic attacks. So those were some of the things I dealt with. Insomnia—pretty bad insomnia—really drove me to seek answers because I was kind of falling apart by the time I was in my early 20s [while I was] in medical school, along with the best of us.

Brie Wieselmann 4:07

I would say that the medicine piece ironically happened because in my teens I grew really enamored of plant-based psychedelics. I loved exploring with them, and they're herbs and plants, so I recognized that there was this magic synthesis between plants and humans. So my first venture into studying therapeutic medicine was studying Western and European herbalism in Santa Cruz. So I started learning about plants and how they're available to everyone, and that just kept me going.

Dr. Jill 4:44

Wow. Yes, I love that. There are so many parallels. I was a vegetarian [or] vegan from [age] 14 until [age] 25, and I always say it almost killed me. It's not that I'm opposed to vegetarianism by any means; I have a lot of [vegetarian] patients, and I support them. And I'm actually primarily plant-based still. But the difference was that, like you, I was not healthy in the way I looked at [nutrition]. It was [a] carbatarian [diet], basically, and processed soy, substitutes of—

Brie Wieselmann 5:08

A processed soyatarian? [laughing]

Dr. Jill 5:09

Yes, right. So now I look back and I'm like, "Oh my gosh!" And I had cancer 25. I look at that diet, and I think part of that was leading [me in the wrong direction], and I didn't know I had celiac [disease], so I was eating a lot of gluten. We don't need to talk about my story because people have heard it, but it's so parallel. Our choices really do affect our mood and our weight. And even feeling bloated or overweight—I wasn't really ever overweight, but I didn't feel well in my own body because I was eating the wrong foods and my gut was horribly dysbiotic. So it's interesting to have those experiences ourselves and really understand it on a different level, and it sounds like you have had that journey too.

Brie Wieselmann 5:43

Oh yes. What you just said could have come out of my mouth. [laughing] And then what you're saying is that the big thing for you was immune dysfunction, right? For me, it was hormones. But the thing is that ultimately—what we all come to—it ties back to gut health, right?

Dr. Jill 6:03

Absolutely! Yes, so let's dive in because SIBO is kind of our topic, but I think what you and I both want to do is say, "Well, what else is potentially going on with SIBO?"—because you mentioned even in our emails back and forth, and I know patients can attest to this, that often you're diagnosed and then six months later you're diagnosed again. It's recurrent. People go [through] this cycle, and they're like, "Can I

ever get rid of SIBO?" So first of all, let's talk a little bit about: What is SIBO and what is the connection to IBS?—because often, this label of 'IBS' is really a wastebasket term; it describes the symptoms but doesn't tell the 'why' as far as why you're having the symptoms.

Brie Wieselmann 6:40

Absolutely. Small intestinal bacterial overgrowth—that's SIBO. Many people have heard a lot about this. Essentially, it's the idea that we should have a large amount of bacteria in our colon or large intestine, but our small intestine should be, not sterile, but relatively so. If everything's working appropriately—we have the right motility, we have the right digestive power and secretions, and so on and so forth—then what happens is we kind of maintain that situation. But there are a whole bunch of things that can break or go off that wind up allowing the colonization of bacteria where they shouldn't be—you know, bacteria gone wild in the small intestine. That's basically SIBO, and what that leads to is a lot of the symptoms now known as IBS.

Brie Wieselmann 7:23

We know that most cases of IBS have at least a SIBO component from the research. Basically, if you have bacteria living where they shouldn't be, they are going to ferment anything they can get their hands on that you didn't manage to digest completely. And then that will create gas and bloating and, a lot of times, pain from the distension, inflammation, leaky gut, and so on and so forth, and all of the symptoms that can go along with IBS, [such as] constipation, diarrhea, and so on. The tricky thing is that now we know that basically, SIBO equals IBS, but the thing is that there are all these other digestive pathogens or dysbiotic arrangements that can basically yield the same symptoms. When I was in Chinese medicine school, there was a proverb. I'm probably butchering it because I don't speak Mandarin, but basically, it was something like: You're entitled to have more than one problem at the same time.

Dr. Jill 8:24

Ooh. I just want to pause there because Western medicine is the opposite; it's like everything should be this unifying one-size-fits-all diagnosis and a lot of times that causes doctors to really not look outside that. [They'll say things like], "Well, it can't be anything else because it's this." Or if they don't have an answer or an ICD-9 or 10 code for that they'll say, "Well, it's all in your head" or these things that are not true, and I get so frustrated and patients get so discouraged. I love that you share that!

Brie Wieselmann 8:52

Oh yes. I mean, no discredit at all to any of our medical professionals, but it's so true; it's really a symptom. I see us as victims of the system. Even as patients, that's how

we're conditioned to think from the time we're kids; we're going to look for the one answer. So even people who are well-versed in functional medicine, I'm sure you hear this all the time. You come in, you're working with someone, and when you finally find a new piece of information, [they ask], "Is this the thing that's going to get me better?" And of course, my heart breaks. Oh, of course, you want to just say, "Yes, it's that simple!" But those of us who got into the functional medicine field and surrounding fields are medical truth seekers. We tend to not be afraid of the mystery and the unknown and admit that for every one thing we learn, there are like 10 [other] things we have questions about, and we understand that there are going to be multiple overlying causes.

Dr. Jill 9:43

Oh, this is so good because if you're out there suffering and wondering, "Why am I not getting better?" we're going to go into that, so hang tight. But the other thing that's so important here is that there is no one-size-fits-all, and often it's very, very complex, and there are layers. I'm like you; I'm sitting with the patient, listening, like, "Ah, okay"—in my mind—"we'll have to do this first and then this and then this." And then the topic we're not going to talk a lot about today because we could spend a whole other hour [on it], but mold, Lyme disease, and some of these really complex [illnesses], which are now a huge portion of my practice, [have] so many layers [to them]. I always say that 6–18 months is the minimum for a start, so this is a long haul.

Dr. Jill 10:21

I love that you're talking about the complexity. Well, speaking of complexity—SIBO. Granted, we've described this bacterial overgrowth. You did a fantastic job of describing what it is. I think, according to some of the experts and researchers, that about 80% of IBS at the high end is actually SIBO. But what else can mimic SIBO? Do you want to go into some of the other things that you see as far as treatment and that we need to think about that could also be there that could contribute to them?—either consistent or recurrence of symptoms.

Brie Wieselmann 10:50

Yes, absolutely. You were just saying, [in essence]: I stack my list—"Okay, we have to do this and then this and then this" in this sequential order. There's also an order to the diagnostics, so it's really common that someone comes to see me, and I'm not their first time at the rodeo. They've seen two, three, [or maybe] five really great practitioners. They've maybe even done treatments for SIBO. They know they have SIBO; they can tell me all about it. But a lot of times, the first stop is they never tested stool panels—[that's] just basic. And sometimes they have, but maybe they haven't; they only run one or they haven't run one that really was optimized to look for pathogens versus general bacteria diaspora. So I always have people run two stool panels side by side.

That's a hallmark of how I practice after years of seeing even the best panels—the state-of-the-art panels—in the field miss something and another one catches it.

Brie Wieselmann 11:44

There can be a lot of discussion about that—overdiagnosis and stuff. For example, there are tons of parasites that mimic or trigger inflammatory bowel disorder, or IBS, [such as] giardia lamblia, entamoeba histolytica, cyclospora, cryptosporidium, and even blastocystis hominis, which is a protozoan that can be commensal in some people. I think about my Chinese medicine training—there's the pathogen and there's the terrain. How well we tolerate the things that we have is as important as the name of the bad guy. [With] blasto[cystis]—that's why it's confusing—you can have [it] show up and not be sick from it. But blastocystis is found in 67% of patients with IBS and can in and of itself create symptoms.

Brie Wieselmann 12:37

Other organisms I look for [are] cryptosporidium and B. fragilis. Definitely, your protozoa and pathogenic parasites are biggies. If somebody shows up as having those on stool testing, I absolutely will clear them. There's an order to operations of how I approach these things. I tend to work from the top down and also from the relatively macro to the relatively micro. If I find something that tends to reside predominantly in the upper GI like H. pylori, [which] is a bacteria that falls into that category of 'could be commensal' or 'could be problematic' depending on the criteria and in whom and when, if we have a huge overcolonization of H. pylori—usually it's found in the stomach and the proximal part of the small intestine—that will really radically impede our ability to have optimal hydrochloric acid levels. And I want to talk about that later. That is such a key criterion for re-establishing gut health and having anti-pathogenic activity—basically, our defense mechanisms. I'll treat that first and then go into the larger protozoan parasites and then clear things that fall into the realm of dysbiotic bacteria like SIBO or just dysbiosis, and usually things like fungal overgrowth, which I didn't mention but am about to.

Brie Wieselmann 14:05

Fungal dysbiosis—I'll usually handle that last, although there are a couple of caveats, for example, if someone has SIBO of the methane-dominant type. Around five years ago I started switching it up and treating the fungi first if there was also a SIFO or fungal/candida dysbiosis. I found that that worked better clinically. Later on down the line, I heard ideas around why that was having to do with fungi being able to create a low-oxygen environment and that the methanogens thrive there. I don't know if that's true or not; I just know that typically when I treat them in that order, it works better. So those are some of them.

Brie Wieselmann 14:47

I would say the fungal microbiome is a huge consideration because, gosh, testing for fungi and candida is like the wild west; it's tough. The reason is that they're hard to find. They are smart. The gold standard, obviously, is aspirate, which is invasive—going in and getting a sample of the fluid and looking [to see] if they're there. But that's not practical in the clinic, so none of us do that outside of studies. Stool testing—obviously, you can look for markers of candida and other dysbiotic fungi there, but they can be hard to catch. That's sometimes by virtual location, so what you're seeing on a stool panel is often mostly reflective of what's in the colon. But the thing about candida in particular is that it can really colonize anywhere along the GI tract. You're not always seeing the same rate of shed. Also, it's sneaky and transitions between fungi and yeast forms. Just like other micro molds, it can go intracellular and can hide or not shed and then shed. So there are various ways that you can detect that—organic acids, antibodies to candida, and stool testing being some of the main ones.

Brie Wieselmann 16:07

What I find is that a lot of times the most common symptoms of fungal overgrowth, especially the small intestine kind, are exactly the same as SIBO—belching, bloating, indigestion, nausea, diarrhea, gas, and constipation. There were actually studies done in 2015 [that found] that 25% of patients with unexplained GI symptoms did have SIFO—small intestinal fungal overgrowth. A clue for me is if it worsened after someone was treated with rifaximin/neomycin, right?—[It's] fuel on the fungal fire. So those are some of the biggies.

Brie Wieselmann 16:44

I think the overarching take-home [message] is not to settle on one pathogen or one problem there and to make sure that we're [being] complete in our investigation. Like, "What else might be contributing?" And a lot of those organisms like to party together, right? Basically, you'll see that the three best friends that anyone could have are Giardia, blasto[cystis], and candida—and I'll throw H. pylori in there. But those guys really are mutually supportive and commensal. You'll often see C. diff. and candida as co-infections—you can go on and on. There are all kinds of partnerships there. But when I see one, I'll often suspect and look a little bit deeper to make sure that we're getting all those, especially when someone doesn't respond to treatment, meaning they keep getting ongoing infections.

Dr. Jill 17:32

I love that overview. [There are] so many pearls of wisdom there. First of all, the fact that you do two stool tests [is interesting]. Sometimes I'll do one and then a few minutes later do another, but I love the idea of actually doing them. Probably most people that see you and definitely [those] that see me as well have been other places

and are like, "We want an answer." So I love that pearl. Because we have no sponsorship or association, can I ask, what tests do you like to use?

Brie Wieselmann 17:54

Yes. I will say it's changed over the years since 2000 something or early aughts. So right now, what I do is run the GI map, and then there's a panel called Parawellness. That's actually old-school technology—triple stains. They're very thorough—it's awesome. What I'd say is that those are the panels I run when I'm looking for pathogens. There are a whole bunch of awesome panels when you're looking to optimize the microbiome, like BiomeFX or something similar—I love those.

Dr. Jill 18:29

Okay, I love that. [It's] very parallel.

Brie Wieselmann 18:30

Right? Is that what you do?

Dr. Jill 18:31

Yes, and I love that you mentioned exactly what I was thinking with candida—organic acid, serum, antibodies, stool—and even then, sometimes, you'll miss it. I will tell you that the old GI Effects [test] which I still occasionally use, or some of those I give are not PCR for the candida, it'll just give a level. If it's 1+—if it's there at all—it's there. I love this because I think we think and practice similarly.

Brie Wieselmann 18:55

Absolutely. One last one to throw in there—I don't often run it anymore, but the doctor's data, they actually culture it out—oxygen-rich environment and all that. But once in a while, you'll find it there when you can't...

Dr. Jill 19:08

You and I [both] know this. But for those of you listening, each stool test has different technologies, so we as practitioners really have to know: What are we looking for? PCR-DNA or are we looking for a culture?—because one might detect it and the other might not, and that's what's tricky. I love that you mentioned Parawellness because parasites, no matter what tests you use, are the most difficult to detect. So if you've been suffering from gut issues forever and you either haven't had a good stool test or whatever, that would be the thing that's probably missing because it's very hard to detect. Would you agree?

Brie Wieselmann 19:37

I would absolutely agree. Yes, definitely.

Dr. Jill 19:40

Sometimes, where I'm highly suspicious, I have a history or whatever, I have a couple of protocols.

Brie Wieselmann 19:47

I've done that, yes.

Dr. Jill 19:49

Good. A couple of other questions. H. pylori [and] blasto[cystis]—I think both of those can be commensal. What would be a decision-making thing that you would do for blasto[cystis] or H. pylori on whether or not to treat [it]? Would you, most of time, treat it if they have symptoms? Or is there any criteria [that helps] you decide which ones to treat and which not to treat?

Brie Wieselmann 20:07

Yes, great question. Blasto[cystis], it's kind of a simple point-and-shoot. By the time someone's coming to me, there usually is a problem, so then I usually would treat it I'm going to say.

Dr. Jill 20:20

Me too.

Brie Wieselmann 20:07

If someone's coming to me, let's say, for something that's strictly in the realm of women's health and hormones and they happen to have blasto[cystis] and they really have no GI complaints and there's other stuff going on, I might not. Why disrupt the microbiome, even in a relatively safe way? Now, with H. pylori, I have this hierarchy of how I think about it. So, one: Is it overgrown—like, actually overgrown? And then two: Are there virulence factors? If there's a virulence factor I'm at least going to treat to try and clear the virulence factor at the bare minimum. And then three: Is the person symptomatic? Those are the three criteria.

Brie Wieselmann 20:58

If someone has overgrowth plus a virulence factor, even if they're not super symptomatic, I might recommend: "Let's use some probiotics that inhibit it" or "some things that disrupt adherence" like sulforaphane or NAC or something to just dial it back. But if someone's symptomatic and has either of those factors, then for sure we're going to try and change it.

Dr. Jill 21:20

Okay, I love that. Methane SIBO is the other thing I had questions about because I know our listeners who've had SIBO—that might be the one that comes back. I find that to be the most common recurrence. It's hard, right?

Brie Wieselmann 21:31

It's a hard one, yes.

Dr. Jill 21:32

Yes, and just for [those of] you [who are] listening, basically, there's hydrogen SIBO, there's methane SIBO, and there's hydrogen sulfide SIBO, which we can now test. What do you typically do? Do you do the breath tests as well for those? And do you have any particular favorites for breath?

Brie Wieselmann 21:44

I do. I'm a real stickler about the breath test. I get that there are a lot of ways we can find suggestions for sure; you can look at stool panels and other markers and find suggestions of it; you can suspect it based on history and symptoms. I do like the breath test. Again, I've danced around over the years with the different testing [methods available]. I am currently using primarily the trio-smart [test], which has the three gases. I love that we can finally get tested for hydrogen sulfide. What a relief, right?

Dr. Jill 22:10

Me too. Finally.

Brie Wieselmann 22:13

But I'm redoing something that I used to do. Before Biohealth Labs closed, they offered a test that used three substrates for testing. So I'm going back to adding in the fructose based on the data. Actually, there was just a recent talk with Jason Harlock about this.

Dr. Jill 22:35

Yes. There was—the same thing—a very recent article about how big of a deal fructose is.

Brie Wieselmann 22:39

Yes, and he did this genius quantification of the data, and I was like, "Oh, so I thought it was like that—now we know it's like that." So thanks, Jason. But yes, we're going back to instituting fructose testing parallel to lactulose every time we bother to test for SIBO.

Dr. Jill 22:56

Do you do that with that same kit or a different [one]?

Brie Wieselmann 23:00

We're doing it right now with a different kit, but I'm actually trying to figure out what the best way to do it is.

Dr. Jill 23:06

Keep me posted, because the exact same thing, I'm like, "How do we do this?"

Brie Wieselmann 23:10

Absolutely, yes.

Dr. Jill 23:11

I love that, though. We've talked about the diagnosis. People have a pretty good idea of the other things. I want to, in just a minute, go to what you mentioned: The hydrochloric acid and some of the upstream and downstream things. But before we do, let's talk just briefly about, say, blasto[cystis]—there are herbal and medication treatments. What are some of the common things you would use for the protozoa? And then let's talk about *H. pylori*. And then let's talk briefly about SIBO treatments.

Brie Wieselmann 23:39

Oh, yes, great, okay. Blasto[cystis]—I have not had much of a hard time clearing that herbally. It's usually one of two directions; there are a whole bunch of different anti-parasitic formulas from various companies. One I lean on heavily is GI Microb-X from Designs for Health, but there are a bunch of old-school [ones]. There are all different ones, so sometimes it's a matter of which particular cocktail in what ratios of herbs. But I'll use a product like that. One of the key things that I see is that I think that a lot of times practitioners are a little bit shy based on the dosages that are on a bottle. So when someone's being observed by you, which they are if they're coming to you for

help, I'll dial up those dosages sometimes pretty high. I'll start at the baseline using two caps, three times a day, of a product, but oftentimes I'll go up from there.

Brie Wieselmann 24:32

I'll usually use multiple things, so I have reinstated using more oregano oils. I had laid off [of it] for a while, but then recently I read the research that shows that there are actually prebiotic components of oregano that do promote some of the beneficial [bacteria in the gut]. Judiciously, I'm using it. And then, for someone who has a completely wiped-out beneficial microbiome, I might be a little bit more cautious. I use a lot of the products in the line... You know Biocidin? And even if there's artemisia in a formula, one of the key things I do when there's either a resistant parasite or just something like blasto[cystis], which is known to be a little tougher, is I'll use artemisia. I think of that like how I would... Again, I can't prescribe Diflucan, but what I mean is that you monitor it. If I have any suspicion there's going to be an issue—Artemisia is an herb that can be toxic to the liver if taken for too long or in too high of doses—so I'll run liver enzymes before or after starting it, or if anyone has any symptoms that could be related to strain on the liver, pain, or anything, I will have them stop it right away and re-test to make sure they're okay.

Dr. Jill 25:43

I love it. Again, it's so parallel, and I love that you talked about those because that's exactly the thing I found. Two tricks that you may not know from your doctor or have had are, number one, the dose matters. And I'm like you—I actually push it pretty hard, but that's what gets results. And number two, say someone has persistent candida or SIBO—even in my history of 20 years with Crohn's disease, one reason my gut's in great shape is I have stayed on some low-level herbs to keep that suppressed for years—for years. So some people are like, "Oh, can I be done in eight weeks?" Well, yes, but it'll probably come back—for some people, not everybody. I have a weaker immune system. I have a history of Crohn's [disease], so I definitely need that suppressive dose. But, olive leaf, caprylic acid—there are a few things that I've stayed on [for the] long term.

Brie Wieselmann 26:28

Yes, 100%. That's one of the reasons I particularly love Biocidin. Well, also, I just love Chinese herbs; that's my training. I know the company. But basically, so many of those herbs are prebiotic and they promote the flora, so you can be having this antimicrobial activity going on and not to the exclusion of throwing out the good guys. So I agree. I'll sometimes keep someone on one product or something small and low-key while we move on to the next pieces. Absolutely!

Dr. Jill 27:00

Okay, I love that. Let's switch to *H. pylori*—that's another tricky one. What are some tricks [as far] as herbs and things that are powerful against *H. pylori*?

Brie Wieselmann 27:07

Okay, yes. So I'll use a lot of *Mastica*. Again, I'll dose that up pretty high. Some of the zinc carnosines or the more recent iterations of *PepZin* and stuff. Zinc matters, [particularly] the delivery form. What you're trying to do with zinc is different if you're trying to raise someone's intracellular level versus fight off a cold. So I'll use one that targets the mucosal membranes. And then I like a lot of the newer formulations of the licorice [like] *DGL* and such. But there are newer ones that 'gut guard,' which really are shown in studies to block adherence of *H. pylori* to the membrane.

Brie Wieselmann 27:47

A lot of *H. pylori* [research] is about disrupting its ability to adhere and lowering its numbers. I'll use *L. plantarum*, which is shown to inhibit it. I'll use sulforaphane in different forms, *NAC*; those all block the ability to adhere—that's in particular with *H. pylori*. If we don't have the right acidity in the gut, it's not going to clear. There are so many times people say, "I've had *H. pylori* three or four times." Then, I'm looking at the dysbiotics, the ones from the mouth that show up in the tool panel, and I've got huge levels of staph and strep. "Okay, well, that's because you don't have enough stomach acid to clear this," basically. So then, we'll really focus on things like bitters and using *BT* and *HCL*.

Brie Wieselmann 28:41

It's a little chick in the egg because certain bacteria like *H. pylori* basically deconjugate or break down our stomach acid as a way of ensuring their survival, so they're brilliant like that. But also, we need to restore the acid and clear the bacteria to optimize the *HCL*. So both are true. I'll often do some replacement, but then I want to make sure that it's actually coming back on its own, if possible, barring some other cause.

Dr. Jill 29:06

I love that, and that's where we're going with these root causes. That's one of those things that causes recurrence; it's one of these upstream things. What are some other upstream issues?

Brie Wieselmann 29:14

Oh, gosh! Well, literal upstream? Literal upstream? So I love that you said that. It's funny, probably one of the first things when you started learning gut health, it was like four Rs and all that.

Dr. Jill 29:26

Yes.

Brie Wieselmann 29:27

Okay. So the simplest things are often the most powerful and time-tested. Basically, I think upstream, so literally, I start with the mouth. What's going on in the dental microbiome? Basically, if anyone's practicing gut medicine and not thinking about that, please start paying attention. Most people are now aware of that at this point in time, but there are so many of those gram-negative bacteria that colonize the mouth, and also huge levels of fungi. I've read studies, [and] one of my favorites is where they tested stool panels for candida and [found that] just by having people brush their teeth three times a day, they were able to significantly lower the level of candida in the stool test without any diet change or any treatment. Really, all these things colonize our oral microbiome and our sinuses. Then what happens is that they are swallowed with our food. So we have to take care of the mouth. Ninety-four percent of Americans have some form of gingivitis. So basically, if I have anyone with GI issues, we're going to treat the mouth. But if you have any kind of dental issue, I'll use, again, the Dentalcidin or Biocidin or some kind of silver preparation and just treat the mouth, at least while we're treating the gut.

Brie Wieselmann 30:40

Also, chewing [is important]—how we eat. And really, this is a bigger topic than just chewing. Chewing actually does help allow time for signaling to happen to prime the gut, and it allows all the saliva to do the first stage of digestion, making our carbohydrates and certain parts of the proteins more available to be digested. But the signaling allows for HCL and pancreatic digestive enzyme secretion. But the other thing that happens is that in order to chew our food that much, we have to slow down. We can't be in a rush. This is a really hard one in this day and age because technology hasn't made our lives any simpler. Everybody's so busy.

Brie Wieselmann 31:28

I do want to get back to the actual digestive secretions, but what I see as such a huge driver of all chronic GI issues is really that sympathetic dominance—not enough balance between the gas and the brakes of our nervous system—and that doesn't allow for vagus nerve signaling, which is everything for digestion. If we don't have that proper signaling, our motility shuts down, and everything sits there and ferments. That beautiful coral bloom of bacteria after we get done with a meal happens where it shouldn't, [in other words], not down in the colon but in the small intestine. When our body thinks we're in an emergency state or in 'go mode,' [in essence], it says: "Hey, you

can eat later. Obviously, there's something going on. It's not a good time. You'll be vulnerable if you digest your food." So we don't make all those secretions.

Brie Wieselmann 32:17

I think a lot about things like addressing traumas if they haven't been, and not [through] me but by helping someone resource to find a good match for getting support with that. I think about all the neuroplasticity and gut-brain axis stuff. I love the Gupta program, I love biofeedback, I like frequency-specific microcurrent or at least vagal nerve stem [stimulation], which you can do at home with a little ear TENS device, acupuncture, qigong, EMDR, somatics—there are a million ways. So just getting us to drop into that parasympathetic state is everything—at the very least, just stopping and taking a breath before the meal. It sounds so simple, but it's so profound. And eating it outside if possible when weather permits and wherever you live, actually taking your meal outside and breathing fresh air and hopefully feeling the sun on your face—that stuff's huge; I can't really overemphasize it.

Dr. Jill 33:20

I love that you went there because it's so critical, especially now that people are more stressed than ever and there's just so much going on and the isolation and the pandemic and everything. So it is really critical because this is one of those missing pieces. I remember years ago, I'm in Boulder, I was starting to treat some athletes, and especially if they were training or whatever, I couldn't heal their gut because they're doing trampolines and they're training, and they get this divergence of the splanchnic blood flow that should go to the gut for healing [but] it's all in their periphery—

Brie Wieselmann 33:48

Muscles.

Dr. Jill 33:49

Right? So I always would be like, "Okay, well, decide when you want to be either in between seasons or we can't really focus on this if you're training; it won't work." So [it's the] same idea because they're using all the blood flow to the periphery. So, if you are intensively training and you want to heal your gut, you might want to take a break or decide timing-wise [when to receive treatment] because you're, again, in your sympathetic system and not really able to rest, relax, and restore. But I love that you mentioned that. Oh, my gosh! We covered so much. Let me think about what else is [there]—we talked about treatment protocols. Methane—we didn't talk a lot about methane; I feel like that's a tricky one. There are the classical medication routes that always require a couple of medications, but what about herbs?—because I feel like

herbs can be a little tricky. I have a few things that I like. But what do you like to use for methane SIBO?

Brie Wieselmann 34:37

My basis is always garlic. The allicin—that's always a given, and then I rotate in the other things. So I'll use a lot of A.D.P. oregano. For everyone out there, it's a form that releases a little bit more slowly without having a time-release coating, basically, and can give a little more access. So I'll use that. I'll definitely use a lot of probiotics, but specific ones. I'll tend to incorporate some biofilm disruptors with that one. Sometimes [I'll use] something like Biofilm Phase-2 that has a little bit more potent activity because of the bismuth. [I'll also use] at least some of the enzyme-based biofilm disruptors. [I'll use] oregano sometimes. Sometimes [I'll use] more berberine, but definitely, the garlic is the backbone. But I agree with you, it's more challenging, and sometimes it takes a little bit more—I don't want to say guess and check—but you do a little bit of one, based on the other information at hand, you see what it does, and if not, you switch directions. I definitely do some of that with it.

Brie Wieselmann 35:46

I think that a lot of the time, the inclusion of something anti-fungal, even without a strict fungal diagnosis [or] a full-fledged anti-fungal program, has been helpful. That's another thing that I'll do. So, whether that's just some propolis, some caprylic acid type thing, or some lauricidin. Those have, sometimes I've seen, been big boosters.

Brie Wieselmann 36:11

What I didn't really completely talk about was optimizing digestive secretions. What I just wanted to mention, because there's a lot of information about this out there, I rarely, if ever, treat anyone without at least the inclusion of something to promote acid, either bitters or HCL. But I also heavily lean on pancreatic digestive enzyme supports like a lot of pancreatin. Why? Those digest carbs and break down sugars, fats, and starches to some extent. We can see if someone's actually low based on their elastase level on a stool panel. But I have a different marker for what I call low than what the lab will call low. So I want them to be pretty decently high, and that will help prevent unbroken-down food from being fermented. But the key is that we need the right pH for them to work. So, if you just give enzymes to someone who doesn't have the right acidity, they're probably not going to do much. So those are always a combo thing, and I play with the different levels separately. And then with each of those, what happens is that, in turn, we need that pH change to happen in order for bile to be released. So bile is this huge piece. So that was what I really wanted to say is that for methane what I found is that bile, bile, bile. There's almost always a bile problem.

Brie Wieselmann 37:30

Bile release: What happens is basically that we need enough acid to stimulate bile release, and then we need hydration to make enough bile. And so many people with GI issues are dehydrated because it doesn't feel good to drink a lot of water or to have frequent water. So there we go, there's not enough water. And then, they're also deficient in fat-soluble nutrients because they haven't been able to absorb and digest their fats. Now, one of the bile's jobs is obviously to digest fat, but its other job is to absorb toxins to be presented to the liver, and where it's doing that primarily is in the gut. So, if you have a whole bunch of gram-negative bacteria—so you have LPS entering, maybe you also have candida spilling a bunch of ethanol and its metabolites, and parasites with their toxins—the bile gets saturated and carries that to the liver. And then, if it's doing that over and over and over again, day in and day out, with all these other stressors on the system, eventually we can easily get depleted and recycle the bile acids we should have. So I see that as problematic for the rhythm and timing of motility; there's a role that bile has to play with that, [as well as], of course, with being bactericidal; bile is antimicrobial and antifungal. So that's another thing that I see for methane—any clues that someone might not have enough bile.

Dr. Jill 38:58

Oh, you have done such a great job. In our last 40 minutes or so, we've been everywhere. We've really covered a lot, and you are so knowledgeable. I love [it].

Brie Wieselmann 39:06

That was fun!

Dr. Jill 39:07

It really was! It was amazing. I think people are going to really, really, really [enjoy this] and they're going to want to rewind and listen to this again, [with] all those little tips and tricks. I will say, because we mentioned special herbs and very specific things, please consult your medical professional to help you with this. Granted, you can try things, but we're not giving medical advice, and this can be complicated. There are lots of good practitioners like Brie out there that can help you. Speaking of which, Brie, if people want to know more about you, where can they find you? Tell us more about your space and where they can find you.

Brie Wieselmann 39:37

Absolutely! Well, there's always my website, which is [BrieWieselmann.com](http://BrieWieselmann.com). My last name's a little tricky to spell, but don't worry; if you try to find it on Google, you'll get there. We'll also put the link below. And I hang out a lot on Instagram, actually, so if you want to just chat with me there through my profile, I'm available and underneath my posts. And then, I'm available for consultation. I also have a team of three practitioners

and a health coach working with me, and an amazing back-office team to make it all work for you.

Dr. Jill 40:07

Awesome! And you're in Portland did you say, right? Do you do virtual consults too?

Brie Wieselmann 40:13

I am; I'm in Portland. I actually, at this point, only do virtual consults. I moved up here four and a half months ago. I've been in Santa Cruz for 23 years prior, and for about the last five to seven years, I've primarily been virtual. So we work with people all over the US and have worked a lot internationally as well.

Dr. Jill 40:33

Awesome! I will be sure that everywhere you can hear this podcast, wherever you find it, I will link up to Brie. And, Brie, it has been a pleasure. We're going to have to do Part 2. This is so full of good information. Thank you so much for your time today!

Brie Wieselmann 40:46

Oh, my gosh, you're welcome. Thank you so much for having me!

Dr. Jill 40:48

You're welcome!