GERD / Reflux Diet

Fewer triggers, smaller meals, and gravity on your side.

MAINLY USED FOR	CORE RESTRICTION	EFFORT
Acid reflux, LPR, oesophagitis	Trigger foods, meal size, late eating	2 of 5

01 How it works

Reflux happens when the lower oesophageal sphincter relaxes at the wrong time or is mechanically overwhelmed. Some foods relax the sphincter directly — fat, chocolate, mint, alcohol, caffeine. Others do not cause reflux but irritate an already inflamed oesophagus, like citrus, tomato and spice.

Volume and timing matter more than most people expect. A large late meal raises gastric pressure at exactly the point you lie down and lose the help of gravity.

Weight around the abdomen raises intragastric pressure; modest weight loss is one of the few interventions with strong evidence in reflux.

02 Nutrition at a glance

Meal timing, portion size and body position drive reflux at least as much as which foods you choose.

Last meal	3 hours before bed	The best-evidenced change on this list
Meal size	Small, 4–6 a day	Volume raises pressure on the valve
Bed head elevation	15–20 cm	Blocks under the bed, not extra pillows
Fat	Moderate	High-fat meals slow emptying and relax the sphincter
Weight	5–10% loss if overweight	Reliably reduces symptoms

Nutrients that often run short: Vitamin C if citrus and tomato are cut · Fibre · Plant variety · Calcium.

ELECTROLYTES

A word on electrolytes

Any change in how you eat changes how much sodium, potassium and magnesium you take in — usually downwards, because cooking from scratch removes the packaged foods that supplied most of it. Headaches, cramps, lightheadedness on standing and that flat, foggy feeling in the first fortnight are far more often an electrolyte dip than the diet failing. Drink to thirst rather than to a rule, salt your food unless you have been told not to, and lean on potassium- and magnesium-rich whole foods. If you have kidney disease, heart failure or high blood pressure, or you take a diuretic, ACE inhibitor or ARB, set your targets with your clinician — and avoid potassium-based salt substitutes unless told they are safe for you.

03 Key cautions

The things that most often catch people out — worth raising at your next appointment.

TALK TO A CLINICIAN

Alarm symptoms need endoscopy

Trouble swallowing, food sticking, vomiting, weight loss, anaemia or black stools need urgent assessment rather than a diet trial.

WORTH TESTING

Long-standing reflux carries a Barrett's risk

Years of untreated symptoms warrant a conversation about surveillance, not just symptom control.

KEEP AN EYE ON

Trigger lists are personal

Coffee, chocolate, mint, citrus and tomato affect some people and not others. Cut everything for two weeks, then test them individually rather than avoiding all of them for life.

KEEP AN EYE ON

Chest pain is not always reflux

New, exertional or radiating chest pain is a cardiac question until someone rules it out.

04 Conditions it is used for

- Gastro-oesophageal reflux disease
- Laryngopharyngeal reflux — cough, hoarseness, throat clearing
- Erosive oesophagitis and Barrett's oesophagus, alongside medical therapy
- Hiatus hernia symptoms
- Reflux in pregnancy

05 Your food lists

Eat freely

Low-acid, low-fat protein

- Grilled chicken and turkey without skin
- White fish
- Egg whites
- Tofu
- Lean beef in modest portions

Vegetables

- Green beans
- Broccoli
- Asparagus
- Cauliflower
- Cucumber
- Potato
- Leafy greens

Fruit

- Banana
- Melon
- Pear
- Apple

Grains

- Oatmeal
- Brown and white rice
- Wholegrain bread
- Couscous

Eat with care

Common but individual triggers

- Coffee and tea
- Chocolate
- Carbonated drinks
- Garlic and onion
- Cheese and higher-fat dairy
- Large portions of anything, even safe foods

Best to skip

Sphincter relaxers

- Fried and high-fat food
- Chocolate
- Peppermint and spearmint
- Alcohol
- Large amounts of caffeine

Habits, not foods

- Eating within three hours of bed
- Very large meals
- Tight waistbands
- Smoking
- Lying flat without head elevation

Irritants

- Tomato and tomato sauce
- Citrus and citrus juice
- Chilli and hot sauce
- Vinegar-heavy dressings
- Very spicy curries

06 Three days of meals

Day 1

Breakfast: Oatmeal with banana and a spoon of honey.

Lunch: Grilled chicken with couscous, cucumber and steamed green beans.

Dinner: Baked cod, rice, roasted asparagus. Finished by 7pm.

Snack: Pear slices.

Day 2

Breakfast: Egg white omelette with spinach, wholegrain toast.

Lunch: Turkey and lettuce wrap, small side of carrot sticks.

Dinner: Chicken and vegetable soup with potato and celery, no tomato.

Snack: Melon.

Day 3

Breakfast: Porridge with pear compote.

Lunch: Tofu and broccoli over rice with ginger, no chilli.

Dinner: Lean roast beef, mashed potato with olive oil, cauliflower.

Snack: Plain rice cakes.

07 Getting started

- Shrink meals and eat earlier before you start banning foods. Timing and volume beat food lists for most people.
- Raise the head of the bed 15-20 cm with blocks, not extra pillows, which bend you at the waist and make it worse.
- Keep a two-week trigger diary rather than eliminating everything at once.
- Get red flags checked: difficulty swallowing, weight loss, vomiting blood or anaemia need urgent assessment, not diet.
- Review medications. Calcium channel blockers, nitrates, some asthma drugs and NSAIDs all worsen reflux.

08 Common mistakes

- Banning tomato, citrus and coffee forever when only one of them is actually your trigger.
- Snacking constantly to 'buffer acid', which keeps the stomach loaded all day.
- Drinking large volumes with meals.
- Stopping a PPI abruptly, which causes rebound acid hypersecretion — taper with your doctor.
- Treating persistent symptoms as a diet failure when they need endoscopy.

09 Questions people ask

Is there one 'reflux diet'?

No. Trigger foods are individual, and the strongest evidence supports weight loss, smaller meals, earlier dinners and bed elevation rather than any specific food list.

Does alkaline water help?

Evidence is thin. Some small studies on pepsin deactivation in LPR exist; it is unlikely to be the deciding factor for most people.

Should I be low carb?

Some trials show reduced reflux on low carbohydrate diets, possibly through weight loss and reduced fermentation. It is a reasonable trial, not established therapy.

10 How it overlaps with other diets

- GERD advice conflicts with keto's very high fat intake — go moderate-fat if you are combining them.
- Overlaps well with DASH and low fibre approaches, both of which favour moderate, simple meals.

- Combines fine with gluten-free and low FODMAP; reflux triggers are a different axis entirely.

> This guide is educational and is not medical advice. Therapeutic diets can change how medication works and can leave gaps in nutrition, so please plan any of this with your doctor or a registered dietitian.

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