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**Current pharmacological therapies for nonalcoholic fatty liver disease/nonalcoholic steatohepatitis**

Takahashi Y *et al.* Pharmacological therapies for NAFLD/NASH

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**Abstract**

Nonalcoholic fatty liver disease (NAFLD)/nonalcoholic steatohepatitis (NASH) is considered to be a hepatic manifestation of metabolic syndrome, and its incidence is rapidly increasing worldwide. It is currently the most common chronic liver disease. NASH can progress to liver cirrhosis and hepatocellular carcinoma, and may result in liver-related death. Currently, the principal treatment for NAFLD/NASH is lifestyle modification by diet and exercise. However, pharmacological therapy is indispensable because obese patients with NAFLD often have difficulty maintaining improved lifestyles. The pathogenesis of NAFLD/NASH has not been completely elucidated. However, insulin resistance, inflammatory cytokines, and oxidative stress are thought to be important in the development and/or progression of the disease. Currently, insulin sensitizers (thiazolidinediones) and antioxidants (vitamin E) seem to be the most promising therapeutic agents for NAFLD/NASH, and lipid-lowering drugs, pentoxifylline, angiotensin receptor blockers, and n-3 polyunsaturated fatty acids also have promise. However, there is a lack of consensus regarding the most effective and appropriate pharmacotherapy for NAFLD/NASH. Results of animal experiments suggest that herbal medicines and natural products may be promising therapeutic agents for NAFLD/NASH, but their efficacy and safety are yet to be investigated in human studies. In this paper, we review the existing and potential pharmacological therapies for NAFLD/NASH.

**Key words:** Pharmacological therapy; Nonalcoholic fatty liver disease; Nonalcoholic steatohepatitis; Thiazolidinedione; Vitamin E

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**Core tip:** Nonalcoholic fatty liver disease (NAFLD)/nonalcoholic steatohepatitis (NASH) is considered to be a hepatic manifestation of metabolic syndrome. Currently, the principal treatment for NAFLD/NASH is lifestyle modification by diet and exercise. However, establishment of pharmacological therapy is indispensable. Currently, insulin sensitizers (thiazolidinediones) and antioxidants (vitamin E) seem to be the most promising agents for treating NAFLD/NASH, and lipid-lowering drugs, pentoxifylline, angiotensin receptor blockers, and n-3 polyunsaturated fatty acids also have promise; however, there is a lack of consensus regarding the most effective and appropriate pharmacotherapy for NAFLD/NASH. In this paper, we review the existing and potential pharmacological therapies for NAFLD/NASH.

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**INTRODUCTION**

Nonalcoholic fatty liver disease (NAFLD) is characterized by the accumulation of triglycerides in the liver of a patient without a history of excessive alcohol consumption. NAFLD is classified into simple steatosis, in which only hepatic steatosis is observed, and nonalcoholic steatohepatitis (NASH), in which intralobular inflammation and ballooning degeneration of hepatocytes as well as hepatic steatosis are observed. NASH is a progressive disease and may lead to liver cirrhosis and hepatocellular carcinoma[1,2]. Twenty percent of NASH patients are reported to develop cirrhosis, and 30%–40% of patients with NASH cirrhosis will experience a liver-related death[3]. Recently, NASH has become the third most common indication for liver transplantation in America[4].

NAFLD/NASH is considered to be a hepatic manifestation of metabolic syndrome[5]. The incidence of NAFLD/NASH has been rapidly increasing globally in line with the increased prevalence of obesity, and is currently the most common chronic liver disease. Recently, the incidence of NAFLD and NASH was reported to be 46% and 12%, respectively, in a largely middle-aged population[6].

Currently, the principal treatment for NAFLD/NASH is lifestyle modification by diet and exercise. At present, there is a lack of consensus regarding the most useful and appropriate pharmacological therapy. However, establishment of pharmacological therapy is indispensable because obese patients with NAFLD often have difficulty maintaining improved lifestyles. In this paper, we review the existing and potential pharmacological therapies for NAFLD/NASH.

**PATHOGENESIS OF NAFLD/NASH**

Understanding the pathogenesis of NAFLD/NASH is important for the development of suitable drugs. Although the pathogenesis of NAFLD/NASH has not been completely elucidated, the “two-hit”[7] and “multiple parallel hit”[8] hypotheses have been proposed. In the “two-hit” hypothesis, hepatic steatosis occurs first and progresses to NASH by subsequent second hits. Hepatic steatosis results from an imbalance between triglyceride accumulation and elimination in the liver. Insulin resistance (IR), which is frequently seen in obese individuals, is tightly linked to this process, as it alters nutrient distribution among tissues and nutrient metabolism[9]. Peripheral IR leads to an influx of free fatty acids to the liver both by decreased suppression of lipolysis and increased *de novo* lipogenesis in the liver[10]. The renin-angiotensin-aldosterone system plays a central role in IR and is associated with NAFLD/NASH[11]. Hepatic inflammation is caused by increased levels of inflammatory cytokines (*e.g.,* tumor necrosis factor [TNF]-α, interleukin-6), decreased levels of antiinflammatory cytokines (*e.g.,* adiponectin), oxidative stress, and endotoxins originating from intestinal bacterial flora.

**PHARMACOLOGICAL THERAPY FOR NAFLD/NASH**

***Insulin sensitizers***

Since IR is a major mechanism in the development and progression of NAFLD, the potential therapeutic effect of insulin sensitizers on NAFLD/NASH has gathered much attention. Thiazolidinediones (TZDs) are peroxisome proliferator-activated receptor (PPAR)-γ agonists and increase insulin sensitivity. Rosiglitazone and pioglitazone are representative TZDs. Rosiglitazone was shown to improve steatosis and aminotransferase levels in patients with NASH in a randomized controlled trial[12]. However, usage of rosiglitazone has been restricted because it has an obvious side effect of increasing the risk of heart attack (ischemic heart disease). Usage of rosiglitazone is prohibited in Europe according to the recommendations of the European Medicines Agency, and it is highly restricted in America based on the recommendations of the Food and Drug Administration (FDA).

In randomized controlled trials, administration of 30 or 45 mg/day pioglitazone induced significant improvements in serum aminotransferase levels and liver histology (steatosis, inflammation, ballooning, and Mallory–Denk bodies) compared with placebo in NASH patients[13-15]. However, improvement in the extent of fibrosis was not significant. American guidelines for NAFLD have recommended the use of pioglitazone in patients with biopsy-proven NASH[16]. Pioglitazone has side effects including weight gain, edema, heart failure, and bone density reduction. In addition, it was reported that the risk of bladder cancer was increased if pioglitazone was used for more than 2 years[17]. Therefore, the usage of pioglitazone for new patients has been prohibited in France and Germany. In America, the FDA currently recommends avoidance of pioglitazone if active bladder cancer is present, and caution if there is history of the disease[18].

Metformin is classified as a biguanide, and is used to treat type 2 diabetes mellitus. Metformin increases insulin sensitivity by decreasing hepatic gluconeogenesis and limiting triglyceride production[19]. In pilot studies, metformin was shown to improve fatty liver disease and reverse hepatomegaly, steatosis, and aminotransferase abnormalities in a mouse model of NAFLD[20], as well as improve serum aminotransferase levels and liver histology including steatosis, necroinflammation, and fibrosis in NAFLD/NASH patients[21,22]. However, in a subsequent randomized controlled trial, treatment with metformin for 6 months showed no significant benefits compared with placebo in terms of improvement in liver histology in patients with NAFLD, although it was associated with a reduction in serum levels of lipids and glucose[23]. In a recent randomized controlled trial, metformin was not superior to placebo in attaining sustained reduction of alanine aminotransferase (ALT) levels in patients with pediatric NAFLD[24]. American guidelines for NAFLD do not recommend metformin for the treatment of adult NAFLD[25].

***Antioxidants***

Many studies have examined the therapeutic effects of antioxidants on NAFLD/NASH because oxidative stress is thought to be an important factor for the progression of NAFLD. Vitamin E (α-tocopherol) is a fat-soluble vitamin with antioxidant properties. In a pilot study, daily oral vitamin E administration was shown to normalize serum aminotransferase and alkaline phosphatase levels in children with NASH[26]. In a large randomized controlled trial, vitamin E administration (800 IU/d) for 96 wk significantly improved serum aminotransferase levels, hepatic steatosis, and lobular inflammation compared with placebo in adults with NASH and without diabetes. However, the extent of hepatic fibrosis was not significantly improved[15]. In another randomized controlled trial, administration of vitamin E and C (1000 IU/d and 1000 mg/d, respectively) for 6 mo resulted in a significant improvement in hepatic fibrosis in patients with NASH[27]. In a recent randomized controlled trial, vitamin E (800 IU/d) administration for 96 wk significantly improved hepatocellular ballooning, but it was not superior to placebo in attaining sustained reduction in ALT level in patients with pediatric NAFLD[24]. Based on the results of earlier trials in non-diabetic patients with biopsy-proven NASH, the American guidelines for NAFLD have recommended the use of vitamin E for non-diabetic patients with biopsy-proven NASH[16]. It is important to examine the effects of vitamin E in NASH patients with diabetes.

It is noteworthy that the long-term safety of vitamin E is questionable. It was reported that high-dosage (≥ 400 IU/d) vitamin E supplements may increase all-cause mortality[28]. In addition, it was reported that dietary supplementation with vitamin E significantly increased the risk of prostate cancer among healthy men[29]. It is necessary to investigate the long-term prognoses of NASH patients who take vitamin E supplements.

***Lipid-lowering drugs***

NAFLD is strongly associated with obesity and dyslipidemia. Statins prevent cholesterol synthesis by inhibiting 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase, and are used to treat dyslipidemia. In addition, owing to their possible antiinflammatory effects, statins are an option for treating NAFLD[30]. Atorvastatin and simvastatin are representative statins. In a pilot study, serum aminotransferase and lipid levels were reduced significantly in all patients with NAFLD by atorvastatin treatment; however, histological assessment was not performed[31]. In a subsequent open-label study, liver steatosis and NAFLD activity score (NAS) significantly improved, whereas 4 of 17 (24%) patients with biopsy-proven NASH with hyperlipidemia had increased fibrosis stage after atorvastatin administration[32]. In a randomized controlled trial, atorvastatin (20 mg/d) combined with antioxidants (vitamin C and E) was effective in reducing the risk of hepatic steatosis by 71% after 4 years of active therapy in individuals with NAFLD at baseline[33]. In a randomized controlled trial, simvastatin treatment did not induce significant improvement in serum aminotransferase levels, hepatic steatosis, necroinflammatory activity, or stage of fibrosis in NASH patients[34]. Thus, the efficacy of statins for NAFLD/NASH has not been fully validated. Statins decrease lipid levels both peripherally and viscerally, specifically in the liver[9]. Serum aminotransferase levels may increase transiently when fat is removed from the liver. This transient elevation of serum aminotransferase levels does not progress to liver injury, and decreased fat deposition in the liver will eventually cause a decrease in serum aminotransferase levels. Therefore, even if serum aminotransferase levels mildly increase shortly after the administration of statins, it is not necessary to discontinue the drug. American guidelines have recommended against the use of statins in the treatment of NASH until randomized controlled trials have confirmed their histological efficacy[16]. However, administration of statins may be beneficial in improving metabolic status and reducing the risk of cardiovascular disease.

Ezetimibe is a newer agent that decreases serum lipid levels by inhibiting cholesterol absorption. It was reported that combination therapy with ezetimibe and acarbose (an α-glucosidase inhibitor) for 24 wk improved histopathological findings (steatosis, inflammation, and fibrosis) in a mouse model of NAFLD[35]. In an open-label pilot study, serum aspartate aminotransferase (AST), ALT, and low-density lipoprotein (LDL) cholesterol levels were significantly improved in NASH patients by treatment with ezetimibe (10 mg/d) for 6 mo. In the study, follow-up liver biopsies revealed that steatosis grade and NAS also significantly improved; however, the fibrosis stage did not change significantly[36]. In a subsequent trial, long-term (10 mg/day for 24 mo) ezetimibe therapy significantly improved serum triglyceride, total cholesterol, LDL cholesterol, and ALT levels in NAFLD patients. In the study, histological features of steatosis, necroinflammation, and ballooning significantly improved from baseline, but fibrosis stage did not significantly improve[37]. In a recent randomized controlled trial, ezetimibe administration (10 mg/d for 6 mo) improved hepatic fibrosis but increased hepatic long-chain fatty acid and hemoglobin A1c levels in patients with NAFLD[38].

***Pentoxifylline***

Pentoxifylline is a methylxanthine derivative and nonselective phosphodiesterase inhibitor that inhibits synthesis of TNF-α. Since TNF-α is thought to be important in the progression of NAFLD, pentoxifylline has been investigated as a treatment option for NAFLD/NASH. In addition, pentoxifylline has recently been shown to decrease oxidized lipid product levels in NASH patients[39]. In pilot trials, administration of pentoxifylline for 12 months significantly decreased serum AST and ALT levels compared to baseline, and this correlated well with histological resolution in NASH patients[40,41]. However, randomized controlled trials led to mixed results. Van Wagner *et al*[42] reported that administration of pentoxifylline (1200 mg/d) for 12 months failed to reduce aminotransferase levels compared to placebo in NASH patients. However, Zein *et al*[43] reported that administration of pentoxifylline (1200 mg/d) for 12 mo improved histological features of NASH (steatosis, lobular inflammation, NAS, and fibrosis) compared to placebo. Larger randomized controlled trials are needed in the future to validate the effects of pentoxifylline on NAFLD/NASH. Administration of pentoxifylline requires caution because it causes adverse effects such as nausea and vomiting.

***Ursodeoxycholic acid***

Ursodeoxycholic acid (UDCA) is a hydrophilic bile acid with antiapoptotic and cytoprotective properties. Its effects on NAFLD/NASH have therefore been examined. In a randomized controlled trial, 2 years of therapy with UDCA at a dose of 13–15 mg**/**kgperday did not have significant benefit compared with placebo for patients with NASH[44]. In a subsequent randomized controlled trial, 23–28 mg**/**kgperday UDCA treatment for 18 mo failed to improve overall histology in patients with NASH compared with placebo[45]. A recent randomized controlled trial showed that treatment with high-dose (28–35 mg**/**kgperday) UDCA for 12 months improved aminotransferase levels, serum fibrosis markers, and selected metabolic parameters in NASH patients, but histological assessment was not performed in this study[46]. In a randomized controlled trial, 2 years of treatment with UDCA in combination with vitamin E improved serum AST and ALT levels and hepatic steatosis in patients with NASH[47]; however, this may be primarily due to the effects of vitamin E. American guidelines do not recommend UDCA for the treatment of NAFLD or NASH[25].

***Angiotensin receptor blockers***

The renin-angiotensin-aldosterone system modulates insulin sensitivity and is associated with the pathogenesis of NAFLD/NASH. Thus, the effects of angiotensin II type 1 blockers (*e.g.,* telmisartan, valsartan, losartan) on NAFLD have been investigated. Telmisartan was shown to attenuate steatohepatitis progression by suppressing the infiltration of macrophages into the liver in a mouse model of NASH[48]. In a clinical trial, telmisartan and valsartan decreased serum ALT levels, homeostasis model assessment as an index of insulin resistance (HOMA-IR), and NAS in NASH patients with metabolic syndrome, with telmisartan showing a higher efficacy than valsartan on the HOMA-IR and NAS[49]. In an animal experiment, combined treatment with losartan and deferasirox (an oral iron chelator) attenuated the progression of NASH in rats[50]. In a clinical trial, treatment with losartan resulted in an improvement in serum aminotransferase levels and liver histology (necroinflammation and fibrosis)[51]. However, in an open-label trial, combination therapy with rosiglitazone and losartan conferred no greater benefit than rosiglitazone alone with respect to histopathology[52]. Well-designed randomized controlled trials are needed to confirm the effects of angiotensin receptor blockers on NAFLD/NASH. In addition, the use of angiotensin receptor blockers for normotensive patients requires caution because of their hypotensive effects.

***N-3 polyunsaturated fatty acids***

N-3 polyunsaturated fatty acids (n-3 PUFAs) are PPARα ligands, and have been suggested to play a role in improving NAFLD. Supplementation with n-3 PUFAs ameliorated hepatic steatosis and the degree of liver injury in a rat model of NASH[53]. In a pilot human study, n-3 PUFA supplementation significantly decreased serum AST, ALT, triglyceride, and fasting glucose levels in patients with NAFLD compared with those in controls. Moreover, ultrasonography demonstrated improvement of liver echotexture after n-3 PUFA supplementation[54]. Eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) are major n-3 PUFAs. In a pilot trial, after administration of highly purified EPA (2700 mg/d) for 12 mo, serum ALT levels and liver histology, including steatosis, lobular inflammation, ballooning, and fibrosis improved in most NASH patients[55]. However, in a recent phase 2 trial, ethyl-eicosapentaenoic acid (EPA-E), a synthetic n-3 PUFA, had no significant effect on the histological features of NASH[56]. Although many studies have suggested positive effects of n-3 PUFAs on NAFLD/NASH, conclusions and recommendations for n-3 PUFA supplementation are difficult to establish because the specific quantities and ratios of EPA and DHA were unclear in most published trials.

***Probiotics and synbiotics***

Probiotics are microorganisms that provide health benefits when consumed. Prebiotics are chemicals that induce the growth and/or activity of microorganisms that contribute to the well-being of their host. Synbiotics are nutritional supplements combining probiotics and prebiotics in a synergistic form. Since gut microorganisms play a role in the development of insulin resistance, hepatic steatosis, necroinflammation, and fibrosis[57], the potential benefits of probiotics and synbiotics on NAFLD/NASH have been suggested. In 2003, treatment with VSL#3 probiotic was reported to improve liver histology, reduce hepatic total fatty acid content, and decrease serum ALT levels in an animal model of NAFLD[58]. Subsequently, various studies have shown the beneficial effects of probiotics or synbiotics on animal models of NAFLD/NASH[59-61]. In contrast, in an open label pilot trial, all subjects who received 1 sachet of VSL#3 probiotic daily for 4 mo experienced a significant increase in liver fat content[62]. However, the study had several limitations, including a small number of subjects and use of only one dose and preparation of the probiotic compound. No subsequent clinical studies have reported a similar harmful effect of probiotics. In a randomized controlled trial, the administration of probiotic *Lactobacillus rhamnosus* strain GG (12 billion colony forming unit/d for 8 wk) significantly decreased serum ALT levels compared with the placebo in pediatric obesity-related liver disease patients[63]. In a recent randomized controlled trial, administration of a synbiotic capsule twice daily for 28 wk in addition to lifestyle modification significantly decreased serum ALT and AST levels and fibrosis scores, as determined by transient elastography compared with placebo[64]. Although promising results have been obtained in most of the previous experimental and clinical studies, the effects of probiotics and synbiotics on NAFLD/NASH need to be confirmed in larger randomized controlled trials. In addition, the most effective preparations and dosages need to be established.

***Herbal medicines/natural products***

Various herbal medicines and natural products are known to possess antiinflammatory and antioxidant properties, and their effects on NAFLD/NASH have therefore been anticipated. Japanese herbal medicines (JHMs) (Kampo medicines) are traditional Japanese medicines that are integrated into modern clinical practice. We investigated the effects of four kinds of JHMs (shosaikoto [TJ-9], inchinkoto [TJ-135], juzentaihoto [TJ-48], and keishibukuryogan [TJ-25]) on a mouse model of NASH (methionine- and choline-deficient diet-fed db/db mice), and showed that TJ-9 and TJ-48 inhibited necroinflammation and fibrosis in the liver[65] (Figure 1). We also found that not only TJ-9 and TJ-48, but also TJ-135, inhibited necroinflammatory activity in another mouse model of NASH (high-fat [HF] diet-fed db/db mice)[66]. Recently, it was reported that bofutsushosan (TJ-62), an anti-obesity JHM, attenuated the progression of HF diet-induced NASH in mice[67]. In a small-scale retrospective study, TJ-25 administration led to a significant improvement in liver injury test results and blood cholesterol levels in all NAFLD patients examined[68].

Resveratrol is a polyphenol with antioxidant, antiinflammatory, antiproliferative, and antiangiogenic effects, and plays a potentially important role in many disorders[69]. It was shown that resveratrol improves IR and NAFLD severity in rats, and this effect was suggested to be associated with activation of AMP-activated protein kinase[70,71].

In an epidemiological study, increased consumption of green tea was associated with decreased serum concentrations of total cholesterol and triglycerides and an increased concentration of high-density lipoprotein cholesterol together with a decreased concentration of low- and very low-density lipoprotein cholesterol. Moreover, increased consumption of green tea was related to decreased concentrations of serum AST and ALT[72]. Green tea extracts attenuated hepatic steatosis by decreasing adipose lipogenesis and enhancing hepatic antioxidant defenses in a mouse model of NAFLD[73,74]. In addition, (-)-epigallocatechin-3-gallate, the major polyphenol found in green tea, improved plasma ALT concentrations and hepatic steatosis in HF diet-fed mice[75].

The leaves of eucalyptus (*Eucalyptus globulus*) and banaba (*Lagerstroemia speciosa L.*) are used as traditional remedies for diabetes mellitus. We found that extracts of these leaves reduced lipogenesis, oxidative stress, and inflammatory cytokine expression, and thus inhibited NASH induced by excessive ingestion of fructose in rats (unpublished data). Reports on positive effects of herbal medicines and natural products on animal models of NAFLD/NASH have been increasing, and human studies are needed in the future.

**CONCLUSION**

As reviewed in this paper, many animal experiments and clinical studies have been performed to investigate the effects of various drugs on NAFLD/NASH. However, there is a lack of consensus regarding the most effective and appropriate pharmacotherapy for this disease. The mechanism of action and limitations/demerits of each pharmacotherapy are summarized in Table 1. Currently, insulin sensitizers (TZDs) and vitamin E seem to be the most promising. However, they cause side effects such as weight gain and increases in all-cause mortality, respectively. Better understanding on the long-term safety and efficacy of these drugs is needed before they can be fully incorporated into clinical practice. Pentoxifylline, statins, angiotensin receptor blockers, and n-3 PUFAs have some promise, but their effects should be validated by large-scale and well-designed clinical trials. Results of animal experiments suggest that herbal medicines and natural products may be promising as therapeutic agents for NAFLD/NASH. However, their efficacy and safety need to be investigated in clinical studies. Continuous clinical and preclinical studies on existing and potential drugs are needed to improve treatment for NAFLD/NASH, which is an increasingly prevalent disease.

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**Figure 1 Effects of a Japanese herbal medicine on the liver histology of an animal model of nonalcoholic steatohepatitis.** A: When db/db mice were fed a methionine- and choline-deficient (MCD) diet, marked hepatic steatosis and scattered foci of lobular inflammation (arrows) were induced; B: When juzentaihoto was added to the MCD diet, liver histology markedly improved (hematoxylin and eosin staining).



**Table 1 Mechanism of action and limitations/demerits of drugs for nonalcoholic fatty liver disease/nonalcoholic steatohepatitis**

|  |  |  |
| --- | --- | --- |
| **Drug** | **Mechanism of action** | **Limitations/demerits** |
| Insulin sensitizers | Improve insulin sensitivity | Obvious side effects (heart attack with rosiglitazone; weight gain, edema, heart failure, and bone density reduction with pioglitazone) |
| Antioxidants (vitamin E) | Attenuate oxidative stress | Long-term safety is questionable (increased all-cause mortality and risk of prostate cancer) |
| Lipid-lowering drugs | Improve dyslipidemia | The efficacy has not been fully validated in clinical trials |
| Pentoxifyllin | Inhibit synthesis of tumor necrosis factor-α | Randomized controlled trials led to inconsistent results. Side effects (nausea and vomiting) |
| Urosodeoxycholic acid | Antiapoptotic and cytoprotective properties | Most randomized controlled trials did not show positive effects |
| Angiotensin receptor blockers | Modulates insulin sensitivity | Randomized controlled trials are lacking. Side effects (hypotension) |
| N-3 polyunsaturated fatty acids | Activate peroxisome proliferator-activated receptor α | Specific quantities and ratios of eicosapentaenoic acid and docosahexaenoic acid are unclear in most trials |
| Probiotics and synbiotics | Control gut microbiota | The most effective preparation and dose have not yet been established |
| Herbal medicines/natural products | Antiinflammatory and antioxidative properties | Effects have not been studied in humans |