



Impact of nutraceuticals on markers of systemic inflammation: Potential relevance to cardiovascular diseases – A position paper from the International Lipid Expert Panel (ILEP)

Massimiliano Ruscica^a, Peter E. Penson^{b,c}, Nicola Ferri^d, Cesare R. Sirtori^a, Matteo Pirro^e, G.B. John Mancini^f, Naveed Sattar^g, Peter P. Toth^h, Amirhossein Sahebkarⁱ, Carl J. Lavie^j, Nathan D. Wong^k, Maciej Banach^{l,m,*}, on behalf of the International Lipid Expert Panel (ILEP) and International Lipid Expert Panel Experts (alphabetically):

Julio Acosta¹, Mutaz Al-Khnefawi², Fahad Alnouri³, Fahma Amar⁴, Atanas G. Atanasov^{5,6,7}, Gani Bajraktari^{8,9,10}, Maciej Banach^{11,12}, Sonu Bhaskar¹³, Bojko Bjelakovic¹⁴, Eric Bruckert¹⁵, Richard Ceska¹⁶, Arrigo F.G. Cicero¹⁷, Xavier Collet¹⁸, Olivier Descamps^{19,20}, Dragan Djuric²¹, Ronen Durst²², Marat V. Ezhov²³, Zlatko Fras^{24,25}, Dan Gaita²⁶, Adrian V. Hernandez^{27,28}, Steven R. Jones²⁹, Jacek Jozwiak³⁰, Nona Kakauridze³¹, Amani Kallel³², Niki Katsiki³³, Amit Khera³⁴, Karam Kostner³⁵, Raimondas Kubilius³⁶, Gustavs Latkovskis^{37,38}, G.B. John Mancini³⁹, A. David Marais⁴⁰, Seth S. Martin⁴¹, Julio Acosta Martinez⁴², Mohsen Mazidi⁴³, Dimitri P. Mikhailidis⁴⁴, Erkin Mirrahimov⁴⁵, Andre R. Miserez^{46,91}, Olena Mitchenko⁴⁷, Natalya P. Mitkovskaya⁴⁸, Patrick M. Moriarty⁴⁹, Seyed Mohammad Nabavi⁵⁰, Devaki Nair⁵¹, Demosthenes B. Panagiotakos⁵², György Paragh⁵³, Daniel Pella⁵⁴, Peter E. Penson⁵⁵, Zaneta Petrulioniene^{56,92}, Matteo Pirro⁵⁷, Arman Postadzhiyan⁵⁸, Raman Puri⁵⁹, Ashraf Reda⁶⁰, Željko Reiner⁶¹, Dina Radenkovic⁶², Michał Rakowski^{63,64}, Jemaa Riadh⁶⁵, Dimitri Richter⁶⁶, Manfredi Rizzo⁶⁷, Massimiliano Ruscica⁶⁸, Amirhossein Sahebkar⁶⁹, Naveed Sattar⁷⁰, Maria-Corina Serban⁷¹, Abdulla M.A. Shehab⁷², Aleksandr B. Shek⁷³, Cesare R. Sirtori⁷⁴, Claudia Stefanutti⁷⁵, Tomasz Tomasik⁷⁶, Peter P. Toth⁷⁷, Margus Viigimaa⁷⁸, Pedro Valdivielso⁷⁹, Dragos Vinereanu⁸⁰, Branislav Vohnout^{81,82}, Stephan von Haehling⁸³, Michal Vrablik⁸⁴, Nathan D. Wong^{85,86}, Hung-I Yeh^{87,88}, Jiang Zhisheng⁸⁹, Andreas Zirlik⁹⁰

¹ Cátedra de Cardiología Clínica de la Escuela Médica Razetti de la Universidad Central de Venezuela, Caracas, Venezuela

² Al-Qadisiyah University, Faculty of Medicine, Department of Internal Medicine, Diwaniya City, Iraq

³ Cardiovascular Prevention Unit, Adult Cardiology Department, Prince Sultan Cardiac Centre Riyadh, Saudi Arabia

⁴ Unit of Diabetes & Metabolism, Alexandria University, Alexandria, Egypt

⁵ Institute of Genetics and Animal Biotechnology of the Polish Academy of Sciences, Jastrzebiec, Poland

⁶ Department of Pharmacognosy, University of Vienna, Vienna, Austria

⁷ Ludwig Boltzmann Institute for Digital Health and Patient Safety, Medical University of Vienna, Vienna, Austria

⁸ Institute of Public Health and Clinical Medicine, Umeå University, Umeå, Sweden

⁹ Clinic of Cardiology, University Clinical Centre of Kosovo, Prishtina, Kosovo

¹⁰ Medical Faculty, University of Prishtina, Prishtina, Kosovo

¹¹ Department of Hypertension, Medical University of Lodz, Poland

¹² Cardiovascular Research Centre, University of Zielona-Gora, Zielona-Gora, Poland

¹³ Department of Neurology & Neurophysiology, Liverpool Hospital and South Western Sydney Local Health District, Sydney, NSW, Australia

¹⁴ Clinic of Pediatrics, Clinical Center, Nis, Faculty of Medicine, University of Nis, Serbia

Abbreviations: ACS, acute coronary syndromes; ACE, angiotensin converting enzyme; ARA, arachidonic acid; ASCVD, atherosclerotic cardiovascular disease; BAPs, bioactive anti-inflammatory peptides; BCAA, branched-chain amino acids; BEO, Bergamot essential oil; CHD, coronary heart disease; COVID-19, coronavirus diseases 2019; COX-1, cyclooxygenase-1; CRP, C-reactive protein; CVD, cardiovascular disease; DHA, docosahexaenoic acid; eNOS, endothelial nitric oxide synthase; EPA, eicosapentaenoic acid; FRLFE, flavanol-rich lychee fruit extract; HDL-C, high density lipoprotein cholesterol; HODEs, hydroxydecadienoic acids; HR, hazard ratio; ICAM-1, intercellular adhesion molecule-1; IL-1 β , interleukin-1 β ; ILEP, International Lipid Expert Panel; LA, linoleic acid; LDL-C, low density lipoprotein cholesterol; LOX, lipoxygenase; MCP-1, monocyte chemoattractant protein-1; NAFLD, non-alcoholic fatty liver disease; NLRP3, NLR family pyrin domain containing 3; PAD, peripheral artery disease; PUFA, polyunsaturated fatty acid; RCT, randomized controlled trial; RYR, red yeast rice; TET2, Tet methylcytosine dioxygenase 2; TG, triglycerides; TGF β , transforming growth factor beta; TLR4, toll-like receptor-4; TMAO, trimethylamine-N-oxide; TNF-R, tumor necrosis factor receptor; VEGF-A, Vascular Endothelial Growth Factor-A.

* Corresponding author at: Department of Preventive Cardiology and Lipidology, Medical University of Lodz (MUL), Rzgowska 281/289, 93-338 Lodz, Poland.

E-mail address: maciej.banach@umed.lodz.pl (M. Banach).

- ¹⁵ Pitié-Salpêtrière Hospital and Sorbonne University, Cardio metabolic Institute, Paris, France
- ¹⁶ Third Department of Medicine - Department of Endocrinology and Metabolism of the First Faculty of Medicine, Charles University and General University Hospital, Prague, Czech Republic
- ¹⁷ IRCCS Policlinico S.Orsola-Malpighi, University of Bologna, Italy
- ¹⁸ Institute of Metabolic and Cardiovascular Diseases, Inserm, Toulouse, France
- ¹⁹ Department of Internal Medicine, Centres Hospitaliers Jolimont, Haine Saint-Paul, Belgium
- ²⁰ Department of Cardiology, Cliniques Universitaires Saint-Luc, Brussels, Belgium
- ²¹ Institute of Medical Physiology "Richard Burian" Faculty of Medicine, University of Belgrade, Belgrade, Serbia
- ²² Cardiology Department, Hadassah Hebrew University Medical Center, Ein Kerem, Jerusalem, Israel
- ²³ National Medical Research Center of Cardiology, Moscow, Russia
- ²⁴ Preventive Cardiology Unit, Department of Vascular Medicine, Division of Medicine, University Medical Centre Ljubljana, Slovenia
- ²⁵ Faculty of Medicine, University of Ljubljana, Ljubljana, Slovenia
- ²⁶ Institutul de Boli Cardiovasculare, Universitatea de Medicina si Farmacie Victor Babes din Timisoara, Romania
- ²⁷ Health Outcomes, Policy, and Evidence Synthesis (HOPES) Group, University of Connecticut School of Pharmacy, Storrs, CT, USA
- ²⁸ Vicerrectorado de Investigación, Universidad San Ignacio de Loyola (USIL), Lima, Peru
- ²⁹ the Johns Hopkins Ciccarone Center for the Prevention of Heart Disease, Baltimore, MD, USA
- ³⁰ Department of Family Medicine and Public Health Faculty of Medicine University of Opole, Opole, Poland
- ³¹ Department of Internal Medicine, Faculty of Medicine, Tbilisi State Medical University, Tbilisi, Georgia
- ³² University of Tunis El Manar, Faculty of Medicine of Tunis, Tunis, Tunisia
- ³³ Diabetes Center, Division of Endocrinology and Metabolism, First Department of Internal Medicine, AHEPA University Hospital, Aristotle University of Thessaloniki, Thessaloniki, Greece
- ³⁴ Department of Cardiology, UT Southwestern Medical Center, Dallas, TX, USA
- ³⁵ Mater Hospital, University of Queensland, St Lucia, QLD, Australia
- ³⁶ Department of Rehabilitation, Medical Academy, Lithuanian University of Health Sciences, Kaunas, Lithuania
- ³⁷ Institute of Cardiology and Regenerative Medicine, Faculty of Medicine, University of Latvia, Riga, Latvia
- ³⁸ Pauls Stradins Clinical University Hospital, Riga, Latvia
- ³⁹ Department of Medicine, Division of Cardiology, University of British Columbia, Vancouver, British Columbia, Canada
- ⁴⁰ Chemical Pathology Division of the Department of Pathology, University of Cape Town Health Science Faculty, Cape Town, South Africa
- ⁴¹ Ciccarone Center for Prevention of Heart Disease, Division of Cardiology, Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, MD, USA
- ⁴² Medico Cardiólogo de la Policlínica Metropolitana, Caracas, Venezuela
- ⁴³ Department of Twin Research and Genetic Epidemiology, King's College London, St Thomas' Hospital, Strand, London, UK
- ⁴⁴ Department of Clinical Biochemistry, Royal Free Campus, University College London Medical School, University College London (UCL), London, UK
- ⁴⁵ Kyrgyz State Medical Academy, Bishkek, Kyrgyzstan
- ⁴⁶ diagene Research Institute, Reinach, Switzerland
- ⁴⁷ Dyslipidaemia Department, Institute of Cardiology AMS of Ukraine, Ukraine
- ⁴⁸ Belarusian State Medical University, Minsk, Belarus
- ⁴⁹ Division of Clinical Pharmacology, Division of Internal Medicine, University of Kansas Medical Center, Kansas City, Kansas, USA
- ⁵⁰ Applied Biotechnology Research Center, Baqiyatallah University of Medical Sciences, Tehran, Iran
- ⁵¹ Department of Clinical Biochemistry, the Royal Free London NHS Foundation Trust, Pond Street, London, UK
- ⁵² School of Health Science and Education, Department of Nutrition and Dietetics, Harokopio University of Athens, Athens, Greece
- ⁵³ Department of Internal Medicine, Faculty of Medicine, University of Debrecen, Debrecen, Hungary
- ⁵⁴ 1st Department of Internal Medicine, Faculty of Medicine, Pavol Jozef Safarik University, Košice, Slovakia
- ⁵⁵ School of Pharmacy and Biomolecular Sciences, Liverpool John Moores University, Liverpool, UK
- ⁵⁶ Vilnius University Faculty of Medicine, Vilnius, Lithuania
- ⁵⁷ Department of Medicine, University of Perugia, Perugia, Italy
- ⁵⁸ Bulgarian Society of Cardiology, Medical University of Sofia, Sofia, Bulgaria
- ⁵⁹ I P Apollo Hospital, New Delhi, India
- ⁶⁰ Menoufia University, President of EAVA, Egypt
- ⁶¹ University Hospital Center Zagreb, Department of Internal Medicine, School of Medicine, University of Zagreb, Zagreb, Croatia
- ⁶² Health Longevity Performance Optimisation Institute, Cambridge, UK
- ⁶³ International Lipid Expert Panel, Poland
- ⁶⁴ The Bio-Med-Chem Doctoral School of the University of Lodz and Lodz Institutes of the Polish Academy of Sciences / University of Lodz, Faculty of Biology and Environmental Protection, Department of Molecular Biophysics, University of Lodz, Lodz, Poland
- ⁶⁵ Laboratory of Biochemistry, Faculty of Medicine of Tunis, Rabta Hospital, University of Tunis El Manar, Tunis, Tunisia
- ⁶⁶ Cardiac Department, Euroclinic, Athens, Greece
- ⁶⁷ Biomedical Department of Internal Medicine and Medical Specialties, University of Palermo, Palermo, Italy
- ⁶⁸ Department of Pharmacological and Biomolecular Sciences, University of Milan, Milan, Italy
- ⁶⁹ Biotechnology Research Center, Pharmaceutical Technology Institute, Mashhad University of Medical Sciences, Mashhad, Iran
- ⁷⁰ Institute of Cardiovascular and Medical Sciences, University of Glasgow, Glasgow, UK
- ⁷¹ Department of Functional Sciences, Discipline of Pathophysiology, "Victor Babes" University of Medicine and Pharmacy, Timisoara, Romania
- ⁷² Medical Education Department, United Arab Emirates University, Al Ain, United Arab Emirates
- ⁷³ Department of Ischemic Heart Disease and Atherosclerosis, Republican Specialised Center of Cardiology, Tashkent, Uzbekistan
- ⁷⁴ Dipartimento di Scienze Farmacologiche e Biomolecolari, Università di Milano Centro Dislipidemie, Grande Ospedale Metropolitano, Niguarda Ca'Granda President, Fondazione Carlo Sirtori
- ⁷⁵ Department of Molecular Medicine, Sapienza University of Rome, Rome, Italy
- ⁷⁶ Department of Family Medicine, Jagiellonian University Medical College, Krakow, Poland
- ⁷⁷ The Johns Hopkins Ciccarone Center for the Prevention of Heart Disease, Baltimore, MD, USA
- ⁷⁸ Tallinn University of Technology, North Estonia Medical Centre, Tallinn, Estonia
- ⁷⁹ Catedrático de Medicina, Departamento de Medicina y Dermatología, Universidad de Málaga, Spain
- ⁸⁰ Cardiology Department, University and Emergency Hospital, Bucharest, Romania, University of Medicine and Pharmacy Carol Davila, Bucharest, Romania
- ⁸¹ Institute of Nutrition, Faculty of Nursing and Health Professional Studies and Coordination Centre for Familial Hyperlipoproteinemias, Slovak Medical University in Bratislava, Bratislava, Slovakia
- ⁸² Institute of Epidemiology, School of Medicine, Comenius University, Bratislava, Slovakia
- ⁸³ Department of Cardiology and Pneumology, Heart Center Göttingen, University of Göttingen Medical Center, Georg-August-University, Göttingen, Germany
- ⁸⁴ 1st Faculty of Medicine, Charles University and General University Hospital, Prague, Czech Republic
- ⁸⁵ Department of Medicine, School of Medicine University of California, Irvine, CA, USA
- ⁸⁶ Heart Disease Prevention Program, Division of Cardiology, University of California, Irvine, California, USA
- ⁸⁷ Department of Medicine, Mackay Medical College, Taipei, Taiwan
- ⁸⁸ Cardiovascular Division, Department of Internal Medicine, MacKay Memorial Hospital, Taipei, Taiwan
- ⁸⁹ Institute of Cardiovascular Disease, University of South China, Hengyang, Hunan, China
- ⁹⁰ University Heart Centre Freiburg University, Department of Cardiology and Angiology I, Faculty of Medicine, University of Freiburg, Freiburg, Germany
- ⁹¹ University of Basel, Basel, Switzerland
- ⁹² Vilnius University Hospital Santaros Klinikos, Vilnius, Lithuania

^a Department of Pharmacology and Biomolecular Sciences, Università degli Studi di Milano, Milano, Italy^b School of Pharmacy and Biomolecular Sciences, Liverpool John Moores University, Liverpool, UK^c Liverpool Centre for Cardiovascular Science, Liverpool, UK^d Department of Pharmaceutical and Pharmacological Sciences, Università degli Studi di Padova, Padova, Italy^e Internal Medicine Section, Department of Medicine and Surgery, University of Perugia, Perugia, Italy^f Center for Cardiovascular Innovation, University of British Columbia, Vancouver, BC, Canada^g Institute of Cardiovascular and Medical Sciences, University of Glasgow, United Kingdom^h Cicarrone Center for the Prevention of Cardiovascular Disease, Johns Hopkins University School of Medicine, Baltimore, MD, USAⁱ Biotechnology Research Center, Pharmaceutical Technology Institute, Mashhad University of Medical Sciences, Mashhad, Iran^j Department of Medicine, John Ochsner Medical Center, New Orleans, LA, USA^k Heart Disease Prevention Program, Division of Cardiology, University of California Irvine, Irvine, CA, USA^l Department of Hypertension, Medical University of Lodz (MUL), Lodz, Poland^m Cardiovascular Research Centre, University of Zielona Gora, Zielona Gora, Poland

ARTICLE INFO

Keywords:

Cardiovascular disease

C-reactive protein

Inflammation

Nutraceuticals

Omega-3

Position paper

Red-yeast rice

ABSTRACT

Inflammation is a marker of arterial disease stemming from cholesterol-dependent to -independent molecular mechanisms. In recent years, the role of inflammation in atherogenesis has been underpinned by pharmacological approaches targeting systemic inflammation that have led to a significant reduction in cardiovascular disease (CVD) risk. Although the use of nutraceuticals to prevent CVD has largely focused on lipid-lowering (e.g. red-yeast rice and omega-3 fatty acids), there is growing interest and need, especially now in the time of coronavirus pandemic, in the use of nutraceuticals to reduce inflammatory markers, and potentially the inflammatory CVD burden, however, there is still not enough evidence to confirm this. Indeed, diet is an important lifestyle determinant of health and can influence both systemic and vascular inflammation, to varying extents, according to the individual nutraceutical constituents. Thus, the aim of this Position Paper is to provide the first attempt at recommendations on the use of nutraceuticals with effective anti-inflammatory properties.

© 2021 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Contents

Introduction	42
Opening statement	43
Dietary components, nutraceuticals and anti-inflammatory properties	43
Omega- 6 fatty acids	43
Omega-3 fattyacids	44
Nutraceuticals as non-absorbable agents	46
Nutraceuticals as absorbable agents	46
Dietary plant proteins	48
Soy proteins	48
Lupin proteins	49
Conclusions	49
Declaration of interest	49
Acknowledgment	49
References	49

Introduction

Overactivation of the inflammation cascade is a well-established factor promoting tissue and organ dysfunction in several disease conditions.^{1,2} Increasing evidence demonstrates additional roles for inflammation in the development of arterial diseases.^{1,2} Inflammation is, in fact, an obligatory marker of atherosclerotic cardiovascular disease (CVD; ASCVD), resulting from the inflammatory activity of cholesterol itself as well as from other well-established molecular mechanisms.³ Clinical trials with anti-inflammatory drugs have led to the extensive evaluation of biomarkers, such as high sensitivity C-reactive protein (CRP; hsCRP) and interleukin (IL)-6, which are indicative of increased CVD risk.⁴ The approach to the prevention of atherosclerosis increasingly encompasses the targeting of inflammation⁵ and the increased use of agents targeting inflammatory pathways.⁶

Since inflammation contributes to residual CVD risk after optimal preventive treatments with, e.g. statins, the mechanisms of the inflammatory process have been studied in detail. In terms of molecular

mechanisms, cholesterol crystals in atherosclerotic lesions can promote plaque instability⁷ by activation of NLR family pyrin domain containing 3 (NLRP3) (NACHT-, LRR- and pyrin domain-containing 3). NLRP3 nucleates the assembly of an inflammasome, leading to caspase 1-mediated activation of the interleukin-1 β (IL-1 β) family of cytokines, thus inducing inflammatory pyroptotic cell death.⁸ More recently, the study of mechanisms related to myelopoiesis⁹ has led to important contributions to the understanding of inflammatory mechanisms underlying acute coronary syndromes (ACS) and of potentially protective mechanisms, such as Tet methylcytosine dioxygenase 2 (TET2) production.¹⁰ In addition to drugs specifically affecting this pathway (e.g. canakinumab and colchicine), anti-inflammatory actions of agents in general use in CVD prevention, e.g., statins, have become widely known.¹¹ In line with this evidence, there is also a growing interest in non-drug approaches involving natural products (nutraceuticals) to influence the inflammatory etiology of CVD.¹² The use of nutraceuticals to help to prevent CVD has largely focused on lipid-lowering to date, such as in the documents produced by the International Lipid Expert Panel

(ILEP).¹³ This work, however, has highlighted the potential of these agents to effect inflammatory parameters, and as a consequence, their potential to play a supplemental role in the reduction of inflammation-related residual CVD risk.

Opening statement

In order to provide an objective assessment of nutraceuticals with potential anti-inflammatory activity, the purpose of this Position Paper is to classify nutraceuticals by molecular type and mechanism of action. This will allow us to highlight the most important recent developments in this therapeutic area and to recommend the nutraceuticals with the greatest potential based on the available evidence.

To pursue this aim, the following search algorithm was used to search pubmed.gov (by 31 March 2021): *nutraceuticals* OR *nutraceutical approaches* OR *absorbable nutraceuticals* OR *non-absorbable nutraceuticals* AND *inflammation* AND *atherosclerosis* AND *cardiovascular disease*. Relevant *in vitro*, *in vivo* and clinical studies were included in this review.

The levels of evidence and the strength of recommendation have been weighed and graded according to predefined scales, as outlined in Tables 1 and 2. The experts of the recommendations, based on available data, extensively discussed each nutraceutical finally included in the Position Paper and discussed and agreed on the recommended levels. Due to the limited data, the experts did not decide to evaluate each selected nutraceutical with the class of the evidence. The experts of the writing and reviewing panels completed declaration of interest forms where real or potential sources of conflicts of interest might be perceived (see end of the paper).

Physicians and medical professionals of other specialties treating patients with inflammatory conditions are encouraged to consider the Position Paper in the process of evaluating the clinical status of their patients and to determine and implement medical strategies with the recommended nutraceuticals. However, the Position Paper does not override in any way the individual responsibility of physicians to make appropriate and accurate decisions taking into account the condition of a given patient and in consultation with that patient, and, where necessary, with the patient's guardian or caretaker. It is also the responsibility of health professionals to verify the doses, rules, and regulations applicable to drugs and devices at the time of their *prescription/use*.

Dietary components, nutraceuticals and anti-inflammatory properties

Diet is an important lifestyle determinant of health and can influence inflammation, including vascular inflammation, to varying extents,

Table 1
Classes of recommendation.

Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	Weight of evidence/opinion is in favour of usefulness/efficacy.	Should be considered
Class IIb	Usefulness/efficacy is less well established by evidence/opinion.	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

Table 2
Level of evidence.

Level of evidence	Definition
A	Data derived from multiple randomized clinical trials or their meta-analysis
B	Data derived from single randomized clinical trial or large non-randomized studies
C	Data from preclinical or <i>in vitro</i> studies

according to the individual components of food.¹⁴ Among food-components with a drug-like activity, commonly used nutraceuticals play a major role. A nutraceutical, as per the definition by De Felice (1989), “is a food or part of a food, providing a medical or health benefit. These products may range from isolated nutrients to dietary supplements and specific diets to genetically engineering designed foods, herbal products and processed foods”. It has become customary, in daily practice, to distinguish between nutraceuticals with pharmaceutical-like formulations, in which the composition is standardized, and “functional foods”, i.e., foods with health benefits.^{13,14}

Omega-6 fatty acids

Dietary fatty acids, in particular, omega-6 fatty acids, are major components of daily lipid intake. The predominant polyunsaturated fatty acid (PUFA) is linoleic acid (LA:18:2 n-6), whose intake has been associated, in a number of epidemiological and interventional studies, with reduced CVD risk.^{15,16} A recent assessment of omega-6 PUFA intake among adults in the UK indicated an intake of 10.9 ± 4.7 g/day, most of which (at least 90%) being LA, and which was responsible for about 7% of daily energy intake. LA is converted, through a series of steps, to γ -linolenic acid, dihomo- γ -linolenic acid and to arachidonic acid (ARA).¹⁷ The latter is the major precursor of eicosanoids converted by cyclooxygenase-1 (COX-1) to prostaglandins/thromboxanes. Concentrations of ARA-derived eicosanoids are elevated in people with inflammatory conditions.¹⁸ The pathway to ARA synthesis from LA is generally saturated in the presence of a high intake of LA in humans (likely to be around 10 g/d). Thus, raising LA intake will have no further effect on the promotion of ARA synthesis, and therefore will not alter ARA levels in circulating mononuclear cells (MCs) and inflammatory markers in individuals on a normal diet.¹⁹

The major potential effect of LA itself on inflammation is *via* its metabolism to lipoxygenase (LOX) derivatives, such as the hydroxydecanoic acids (HODEs) and further, to oxo-HODEs and epoxy-HODEs.²⁰ These compounds play a role in inflammation and have been detected in colonic mucosal biopsies of patients with ulcerative colitis without being significantly associated with the degree of inflammation.²⁰

Dietary LA intake was evaluated in a cross-sectional study in 405 healthy men and 454 healthy women and found not to be significantly associated with inflammatory markers, such as CRP, IL-6, soluble (s) tumor necrosis factor receptor (TNF-R) and sTNF-R2.²¹ An epidemiological study in Italy on 1123 subjects (aged 20–98 years) showed that those with the lowest intake of LA had the highest pro-inflammatory IL-6 and CRP.²² However, when multivariable models were used, omega-6 fatty acids were positively associated with IL-1 receptor antagonist (IL-1RA) and negatively with IL-10 and transforming growth factor beta (TGF β), two powerful antiinflammatory cytokines. Similar conclusions were reached in 67 obese individuals randomly assigned to receive either 10-week isocaloric diet high in vegetable n-6 PUFA or SFA mainly from butter. n-6 PUFAs did not cause any signs of inflammation, but instead led to a reduction of IL-1RA and TNF-R2. No changes in CRP, IL-1 β , IL-6 or IL-10 were found.²³

This and other studies have led to the conclusion that, despite a long-held belief to the contrary, available evidence does not support that high

dietary intake or high plasma concentrations of LA raise tissue ARA or alter concentrations of inflammatory markers in humans. Since LA can limit the synthesis of eicosapentaenoic acid (EPA) from α -linolenic acid in humans, there is the possibility that low LA in the background diet might limit endogenous EPA synthesis, potentially creating a more inflammatory environment.²⁴

The lack of a significant anti-inflammatory effect of LA or omega-6 fatty acids in general does not rule out a beneficial action in CVD prevention. Such an effect is supported by the recent Consortium Evaluation of 30 prospective observational studies from 13 countries (follow up ranging between 2.5 and 31.9 years),²⁵ in which high levels of LA were significantly associated with a lower risk of total CVD (hazard ratio [HR]: 0.93; 95% CI, 0.88–0.99), CV mortality (HR: 0.78; 95% CI 0.70–0.85) and ischemic stroke (HR: 0.88; 95% CI 0.79–0.98). ARA levels were not associated with a high incidence of CVD outcomes. However, another recent meta-analysis has not confirmed these results, and Mendelian Randomization results suggested that individuals with genetically higher serum adrenic acid (AA; 22:4,n-6 - naturally occurring PUFA formed through a 2-carbon chain elongation of ARA) levels had a greater risk of coronary heart disease (CHD) events (inverse variance weighting [IVW] = Beta: 0.526, $p = 0.007$), myocardial infarction (MI) (IVW = Beta: 0.606, $p = 0.017$) and stroke (IVW = Beta: 1.694, $p = 0.009$).²⁶

Special members of the omega-6 fatty acid series are the conjugated linoleic acids (CLA), a group of positional and geometric isomers of LA (18:2 n-6). Present in meat and dairy products and synthesized endogenously, CLA can bind peroxisome proliferator-activated receptor α (PPAR α), a nuclear receptor regulating fatty acid catabolism and

inflammatory responses.²⁷ Of special interest for this widely consumed nutraceutical is its activity on neuroinflammation, potentially protective against Alzheimer's disease.²⁸ However, the use of CLA, as well as all other omega-6 fatty acids, by patients, as a general anti-inflammatory awaits more convincing evidence (Table 3, Fig. 1).

Omega-3 fattyacids

Dietary intake of omega-3 fatty acids is essential for health since these PUFAs cannot be endogenously synthesized to a significant extent.²⁹ Omega-3 PUFAs are regarded as anti-inflammatory, exerting their activity *via* multiple mechanisms.²⁹ The basic mechanism is the incorporation of EPA and docosahexaenoic acid (DHA) into cell membranes at the expense of ARA, resulting in inhibited ARA metabolism and the consequent decreased expression of the COX gene and, as a final consequence, reduction of ARA derived eicosanoids.³⁰ Finally, partial inhibition of a number of aspects of inflammation, including leukocyte chemotaxis, adhesion molecule expression and leukocyte-endothelial adhesive interactions, production of inflammatory cytokines, and T-helper 1 lymphocyte reactivity have to be considered.³⁰

More recently, a major advancement in the field of PUFA and inflammation has been the discovery of the so-called pro-resolving lipid mediators produced from EPA and DHA. These mediators include resolvins from EPA (E-series) and DHA (D-series) and protectin and maresin from DHA. Their synthesis involves the COX and lipooxygenase (LOX) pathways operating in a transcellular manner. Early steps can occur in one cell type and the latter in another.³¹ Resolvins and maresins can

Table 3

IILEP recommendations on the effect of nutraceuticals on inflammatory parameters.

Nutraceuticals	Class	Level	Impact on markers of inflammation	References
Omega- 6 fatty acids	IIb	B	No inhibition of CRP, IL-6, soluble (s)TNF-R and sTNF-R2 Positively associated with IL-1RA and negatively with IL-10 and TGF- β , anti-inflammatory cytokines Reduction of IL-1RA and TNF-R2. No changes in CRP, IL-1 β , IL-6 and IL-10	21 22 23
Omega- 3 fatty acids ^a	I	A	EPA + DHA therapy (2.5 g/d) reduced IL-6, IL-1 β and TNF- α Compared with EPA, DHA led to a greater reduction of IL-18 (−7.0% vs −0.5%), hs-CRP (−7.9% vs −1.8%) and TNF- α (14.8% vs −7.6%). Reductions of IL-6 were similar (−12.0% vs −13.4%) Purified EPA may have effect on red cell distribution width (RDW) and its association with chronic inflammation and red blood cells deformability EVOLVE study (omega-3 free fatty acid 2, 3 or 4 g/day) no significant changes in hs-CRP from baseline (−0.3 mg/L) compared with placebo (−0.2 mg/L) REDUCE-IT study (icosapent ethyl 4 g/day) hsCRP: −37.6% (between group difference) STRENGTH study (carboxylic acid formulation of EPA and DHA) hs-CRP: −20.0% in the group receiving omega-3 carboxylic acid formulation vs −6.3% in the placebo arm.	37 39 41,42 47 43 45
Flavonoids	IIa	B	Reduction in IL-1 β and IL-10	75
Curcumin	IIa	B	A significant decrement in serum concentrations of TNF- α , IL-6, TGF- β and MCP-1 TNF- α , −4.69 pg/mL	77 79
Bergamot	III	C	<i>In vitro</i> : decrement in intracellular levels of malondialdehyde/4-hydroxynonenal Preclinical periodontal disease: reduced tissue injury and several markers of gingival inflammation In inflammatory bowel disease: reduce the release of pro-inflammatory cytokines	94 95 96
Garlic	IIb	B	Doses ranging from 1200 to 3600 mg/d for a duration of 2–52 weeks significantly reduced CRP (−0.61 mg/L), IL-6 (0.73 ng/L) and TNF- α (−0.26 ng/L)	97
Berberine	IIb	B	Berberine might attenuate the liver inflammatory response in the livers of rats with high-fat diet-induced NAFLD In the meta-analysis of 5 RCTs showed that serum levels of CRP were significantly decreased after berberine supplementation (−0.64 mg/L).	103 104
RYR ^b	I	A	hsCRP: −50% hsCRP: −28%	110 111
Soy	IIa	A	CRP: soy-nut diet led to a −8.9% compared with red meat diet. IL-18: soy-nuts diet led to −9.2% compared with red meat diet. Meta-analysis: a non-significant 0.19 mg/dL reduction in the levels of hsCRP upon consumption of soy products	128 131
Lupin	III	C	Meta-analysis: significant reduction of hsCRP (−0.27 mg/L; 95% CI −0.51, −0.02) but not IL-6 and TNF- α <i>In vitro</i> data: IQDKEGIPDQQR was the most promising, significantly inhibiting lipoprotein polysaccharide (LPS) induced activation of TNF- α , IL-6, IL-1 β and MCP-1 production by 40–50% at a concentration of 10 μ M.	132 143

Abbreviations: hsCRP, high-sensitivity C-reactive protein; IL, interleukin; MCP-1, monocyte chemoattractant protein-1; NAFLD, non-alcoholic fatty liver disease; TGF- β , transforming growth factor; TNF- α , tumor necrosis factor α ; EVOLVE, Epanova® for Lowering Very High Triglycerides; REDUCE-IT, Reduction of Cardiovascular Events with Icosapent Ethyl–Intervention Trial; STRENGTH, Long-Term Outcomes Study to Assess Statin Residual Risk with Epanova in High Cardiovascular Risk Patients with Hypertriglyceridemia.

^a There are some safety concerns based on the available studies. In the REDUCE-IT trial, an increase in the rate of hospitalization for atrial fibrillation (AF) and peripheral edema in the IPE vs placebo group (5.3% vs 3.9%, $p = 0.003$, and 6.5% vs 5.0%, $p = 0.002$, respectively), were observed.

^b There are some safety concerns on RYR- related muscle adverse events. Based on the European Food Safety Authority (EFSA) Scientific Opinion from 2018, RYR is not available in all countries (e.g. in Switzerland). A new EU/EFSA Regulation is expected on its permissible dosage and safety.

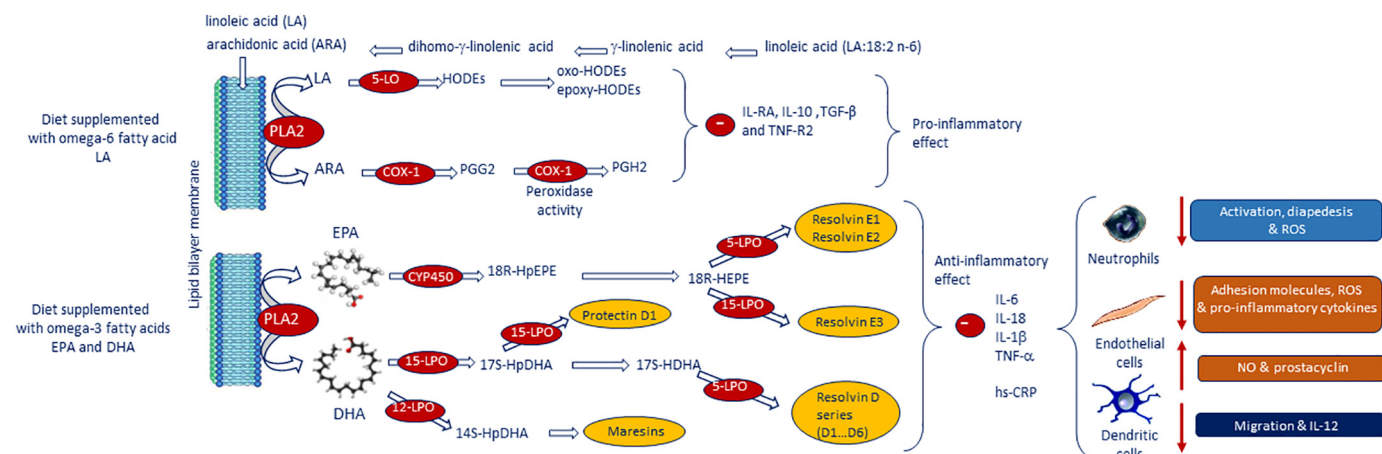


Fig. 1. Role of omega-6 and omega-3 fatty acids on inflammatory pathways.

LA, EPA and DHA are incorporated into the phospholipids of cell membranes at the expense of ARA. LA can also be converted, through a series of steps, to γ -linolenic acid, dihomogamma-linolenic acid and to ARA which is also incorporated into phospholipids of cell membranes. Phospholipase A2 catalyzes the release of LA, ARA, EPA and DHA which undergo intracellular metabolism. LA is converted to proinflammatory mediators oxo-HODEs and epoxy-HODEs while ARA to PGG2 and PPGH2. LA consumption is negatively associated with IL-1RA, IL-10, TGF- β and TNF-R2. EPA and DHA are metabolized by CYP450, 15-lipoxygenase, 12-lipoxygenase and 5-lipoxygenase leading to the formation of the pro-resolving lipid mediators, such as resolvins, protectin, and maresins. These molecules have been shown to reduce the expression of proinflammatory cytokines IL-1 β , IL-6, IL-18 and TNF- α . EPA and DHA have been shown to reduce hs-CRP plasma levels. The anti-inflammatory effect may affect neutrophil activation, diapedesis and ROS synthesis. Reduced expression of adhesion molecules, pro-inflammatory cytokines and ROS production may be observed in endothelial cells. Finally, reduced dendritic cell migration and IL-12 may also be predicted.

Abbreviations: Arachidonic acid (ARA); Docosahexaenoic acid (DHA); Eicosapentaenoic acid (EPA); High-sensitivity C-reactive protein (hsCRP); Interleukin (IL); Linoleic acid (LA); Phospholipase A2 (PLA2); Prostaglandin G2 (PGG2); Prostaglandin H2 (PGH2); Reactive oxygen species synthesis (ROS); Tumor necrosis factor (TNF); Tumor necrosis factor receptor (TNF-R).

be found in humans after EPA or DHA intake³² and have shown anti-inflammatory benefits *in vitro* and in animal models of inflammation.³³ By these mechanisms, omega-3 PUFAs, and especially DHA, decrease the expression of adhesion molecules, such as intercellular adhesion molecule-1 (ICAM-1) on the surface of endothelial and cells and monocyte cultures as well as of the scavenger receptor A in rats fed a high-fat fish oil diet³⁴ (Fig. 1). Interestingly, these properties have now been used in studies on the potential role of omega-3 acids in coronavirus disease 2019 (COVID-19).³⁵

The inhibitory activity of omega-3 fatty acids on the nuclear factor (NF)- κ B is probably exerted by reduced translocation of the NF- κ dimer to the nucleus, where it binds to response elements, thus upregulating inflammatory gene expression. Exposure of macrophages to DHA lowers the ability of toll-like receptor-4 (TLR4) agonists to recruit co-stimulatory molecules, MHC class II, and to stimulate cytokine production.³⁶

A randomized controlled trial (RCT) in ageing adults with chronic venous leg ulcers given EPA + DHA therapy (2.5 g/d) reported reduced IL-6, IL-1 β and TNF- α after 4 and 8 weeks of treatment.³⁷ An ongoing trial will evaluate in 248 eligible adults (≥ 55 years) with chronic venous leg ulcers the effectiveness of EPA (1.87 g/day) + DHA (1.0 g/day) to target and to reduce excessive systemic and local activation of polymorphonuclear leukocytes.³⁸

A direct evaluation of the two fatty acids was carried out by Allaire et al.,³⁹ testing in a double-blind fashion supplementation of EPA and DHA (both 2.7 g/d) vs corn oil (control group) for a period of 10 weeks. Compared with EPA, DHA appeared to lead to a larger reduction of IL-18 (-7.0 vs -0.5%), hsCRP (-7.9% vs -1.8%) and TNF- α (-14.8% vs -7.6%) and to increased adiponectin ($+3.1\%$ vs -1.2%) vs EPA; effects on IL-6 (-12.0% vs -13.4%) were similar. Interestingly DHA led to a more pronounced reduction of triglycerides (-13.3% vs -11.9%) and a greater increase in HDL-C ($+7.6\%$ vs -0.7%) and LDL-C ($+6.9\%$ vs $+2.2\%$) vs EPA. Different conclusions were reached by Pisaniello et al. reporting that supplementation with EPA, more than DHA, ameliorates acute and chronic vascular inflammation. EPA (4 g/day) reduced the expression of C-C motif chemokine ligand 2 (CCL2) by 25% and vascular inflammation compared with placebo.⁴⁰

Additionally, available reports suggest that purified EPA may have an effect on red cell distribution width (RDW) and its association with chronic inflammation and red blood cell deformability.^{41,42}

These findings have gained interest after the positive outcome of the Reduction of Cardiovascular Events with Icosapent Ethyl - Intervention Trial (REDUCE-IT) using a high dose of highly purified EPA (icosapent ethyl, IPE, 4 g/day) given to secondary prevention CVD patients or patients with diabetes and multiple risk factors on statin therapy, but with moderately elevated triglycerides (TG; 135–499 mg/dL).⁴³ This intervention resulted in a primary CVD endpoint reduction of 25% in treated patients.⁴³ At 5 years, these patients had a median reduction in TG levels of -20% with a non-significant change in HDL-C. The lipid findings, particularly those pertaining to TG, were interpreted as not fully explaining the observed large CVD benefit. Interestingly, however, at the last visit, hsCRP levels were reduced by roughly 37%, thus probably adding to the CVD benefit of EPA intake.⁴³ In this context, it is worth recalling that prominent in this area were the previous results of the JELIS (Japan eicosapentaenoic acid (EPA) Lipid Intervention Study) trial, in which hypercholesterolemic patients were randomized to 1.8 g/day high-purity EPA vs placebo. The relative risk of major CHD events was reduced by 19% over a 4.6-year-mean follow-up.⁴⁴ The cardioprotective effects were also observed in a recent meta-analysis of 13 studies with 127,447 individuals, in which the authors showed a significant reduction of the CHD death risk (risk ratio [RR] 0.91, 95% CI 0.85–0.97), major vascular event (0.95, 95% CI 0.93–0.98), non-fatal MI (0.89, 95% CI 0.83–0.95), and all-cause mortality (0.95, 95% CI 0.92–0.99) with omega-3 intervention.⁴⁵

More recently, the REDUCE-IT findings were not confirmed in another secondary prevention trial, this time in patients given a pre-formulated mixture of EPA and DHA (4 g/day). The STRENGTH study did not result in CVD benefits (similarly to all previous studies and trials with the mixture of omega-3 acids) and was terminated early due to a lack of evident protective activity. hsCRP was reduced by -20.0% in the group receiving omega-3 carboxylic acid formulation vs -6.3% in the placebo arm.⁴⁶ Moreover, the EVOLVE (The EpanoVa fOr Lowering Very high triglyceridEs) study did not show significant reduction in the levels of hsCRP from baseline in patients with hypertriglyceridemia

after administration of different daily doses of omega-3 fatty acid (2 g, 3 g or 4 g) vs olive oil (placebo).⁴⁷

Debate on the differences between REDUCE-IT and STRENGTH, besides the different composition of the two formulations, also has to consider differences between the two placebos (mineral oil in REDUCE-IT and corn oil in).⁴⁸ While some have argued whether the effect of mineral oil's on increasing hsCRP may have exaggerated the effects seen in REDUCE-IT, an analysis showed the reduction in REDUCE-IT was similar both in those whose hsCRP increased or not.⁴⁸ Neutral effects from omega-3 were also reported in earlier studies.^{49,50} The ASCEND (A Study of Cardiovascular Events in Diabetes) trial evaluated the efficacy of EPA and DHA in doses recommended by the Nutrition Committee of the American Heart Association, i.e., 460 and 380 mg, respectively. After a mean follow-up of 7.4 years, there was no significant differences between the treatment and placebo groups with respect to the occurrence of a composite MI, stroke, transient ischemic attack, or vascular death: HR of 0.97 (95% CI 0.87–1.08; $p = 0.55$).⁵¹ The superiority vs placebo of similar doses of EPA/DHA to reduce MI, stroke, or CVD death in primary prevention was the objective of the VITAL (Vitamin D and Omega-3 Trial) study.⁵² Over a median of 5.3 years of follow-up, the HR was 0.92 (95% CI, 0.80–1.06; $p = 0.24$)⁵² (Table 3, Fig. 1). Additionally, a major recent meta-analysis of 40 studies in over 135,000 participants demonstrated the marked benefits of this therapy in reducing major CVD outcomes,⁵³ as well as in an updated analysis in 42 studies of 149,000 participants that included the STRENGTH.^{54–56} (Table 3, Fig. 1).

Nutraceuticals as non-absorbable agents

In addition to PUFAs, the evaluation of nutraceuticals extends from dietary components of common foods to non-absorbable and absorbable agents, with recognized anti-inflammatory activities, and to specific functional foods.

Among non-absorbable nutraceuticals, sterols/stanols, soluble fibers (β -glucan, psyllium, glucomannan and non-fiber chitosan) might demonstrate anti-inflammatory properties, among others, due to their clear lipid-lowering activity.¹³ The beneficial impact of *dietary fiber* on circulating CRP levels has been also observed in a comprehensive meta-analysis of RCTs,⁵⁷ however, these results are still limited and inconclusive. An anti-inflammatory action of non-absorbable nutraceuticals has been reported in obese patients with osteoarthritis,⁵⁸ but observational studies have not been still supported by controlled investigations.

Plant Stanol Esters are widely available as rapeseed oil-based spreads, and other phytosterols are commonly-used nutraceuticals for moderate cholesterol reduction (-10 – 15%)^{59,60}; however, potentially rare harmful effects have been observed. These molecules, which affect cholesterol absorption, may lead to hypercholesterolemia and elevated CVD risk in some rare genetic abnormalities of the ABCG5/ABCG8 transporters.⁶¹

Recently an inflammation-like phenomenon appeared to be reduced by plant stanol supplementation (2–3 g/d). Patients with modest cholesterol elevations experienced a clear reduction of low-density lipoprotein (LDL) aggregation after treatment with stanol esters.⁶² The decrease in aggregation was more extensive in participants with a body mass index (BMI) <25 kg/m². Decreased aggregation was associated with a reduced proportion of LDL sphingomyelins and increased LDL triglycerides (TGs). Since LDL particles are more susceptible to aggregation in individuals with established CVD, an aggregation prone-LDL may predict future ASCVD independent of conventional CVD risk factors.⁶³ Further studies are still necessary to confirm their direct and indirect effects on different inflammatory parameters.

Nutraceuticals as absorbable agents

Among absorbable nutraceuticals, *probiotics* can reduce cholesterol by modifying gut flora, in particular, by providing enzymes catalyzing

the transformation of cholesterol into cholest-4-en-one, an intermediate in the conversion to coprostanol or coprostanol, directly excreted into faeces. Probiotics such as *Lactobacillus acidophilus*, *Bifidobacterium bifidum* or *bulgaricus* can reduce the enterohepatic circulation of cholesterol by activation of bile-salt hydrolase,⁶⁴ consequently increasing excretion.⁶⁵ Probiotics may also help to reduce the lecithin/carnitine derived trimethylamine-N-oxide (TMAO) and the consequent inflammatory changes.⁶⁶ The anti-inflammatory activity of probiotics appears to be linked to immune regulation. Activated regulatory T (Treg) cells are reduced by *L. reuteri* in pregnant women in the second half of pregnancy with treatment independent changes in lymphocytes and monocytes and in subpopulations of T-helper cells.⁶⁷ Interest in the clinical use of *L. reuteri* has grown after the positive clinical studies in inflammatory bowel disease.⁶⁸

Among absorbable nutraceuticals, *flavonoids* are enjoying a growing interest. These compounds are widely consumed components of food. Subclasses of flavonoids, including catechins and flavanols, present in cocoa and green tea, have received the most interest.⁶⁹ They exert powerful antioxidant properties, together with the ability to inhibit the secretion of pro-inflammatory cytokines and chemokines from activated endothelial cells. The anti-inflammatory effect of flavanols has been demonstrated in a few studies by the supplementation of FRLFE (flavanol-rich lychee fruit extract).⁷⁰ In healthy individuals, during submaximal and maximal exercise workloads, FRLFE supplementation (100 mg/d for 4 weeks and 2 months) reduced the concentrations of the pro-inflammatory cytokines IL-1 β and IL-6 as well as cortisol. The concentration of TGF- β was increased. Supplementation with FRLFE for 30 days in regular exercising males at maximal workloads also significantly increased time to exhaustion.⁷¹

The anti-inflammatory activity of flavanols may work in harmony with potential vascular protective effects, in particular those exerted by cocoa flavanols.⁷² This recognition has led to the indication of *black flavanol-rich chocolate in blood pressure control*, which also has the potential to improve cognitive performance in the elderly.^{73–75} A large clinical study on the preventive activity of a flavanol-rich cocoa-equivalent in hypertensive patients is ongoing and will also evaluate inflammatory markers (Cocoa Supplement and Multivitamin Outcomes Study (COSMOS)).⁷⁶ This has led to the identification of possible additional indications, such as peripheral artery disease (PAD). A 6-month double-blind RCT in these patients evaluated cocoa (15 g cocoa and 75 mg epicatechin daily) vs placebo. An improvement in the 6-min walk distance at the 6-month follow up, by 42.6 m 2.5 h after the final study beverage and 18 m at 24 h, compared with placebo, was reported.⁷⁷ Data from muscle biopsies in treated patients were clearly indicative of an improvement in microvascular parameters, with significantly raised mitochondrial and capillary densities, possibly dependent on higher VEGF-A (Vascular Endothelial Growth Factor-A) levels.⁷⁸ The antioxidant activity of flavanols does not appear to be related to changes in nitrotyrosine and 4-HNE (hydroxynonenal).⁷⁸ An additional anti-inflammatory activity relates to the reduction of the pro-inflammatory cytokine IL-1- β .⁷⁹ Large studies investigating the flavanol content and inflammatory consequences of a Mediterranean diet, such as the Prevención con Dieta Mediterránea (PREDIMED) study, detected a reduction of inflammatory markers together with a clear CVD benefit⁸⁰ (Table 3, Fig. 2).

Curcumin is a dietary polyphenol derived from the root of *Curcuma longa*, commonly known as turmeric. Curcuma contains approximately 5% curcuminoids by weight. Curcumin has traditionally been used for chemopreventive and antioxidant properties. Potential health benefit in metabolic syndrome has been reported, resulting in a significant decrement in serum concentrations of TNF- α , IL-6, TGF- β and monocyte chemoattractant protein-1 (MCP-1).⁸¹ Whilst curcumin exerts a modest lipid-lowering effect, potentiating the effects of phytosterols,⁸² it also exerts definite antioxidant and anti-inflammatory effects.⁸³ Potential mechanisms underlying this effect are thought to relate to inhibition of NF- κ B and TLR-4 signalling and activation of the PPAR γ pathway.⁸⁴

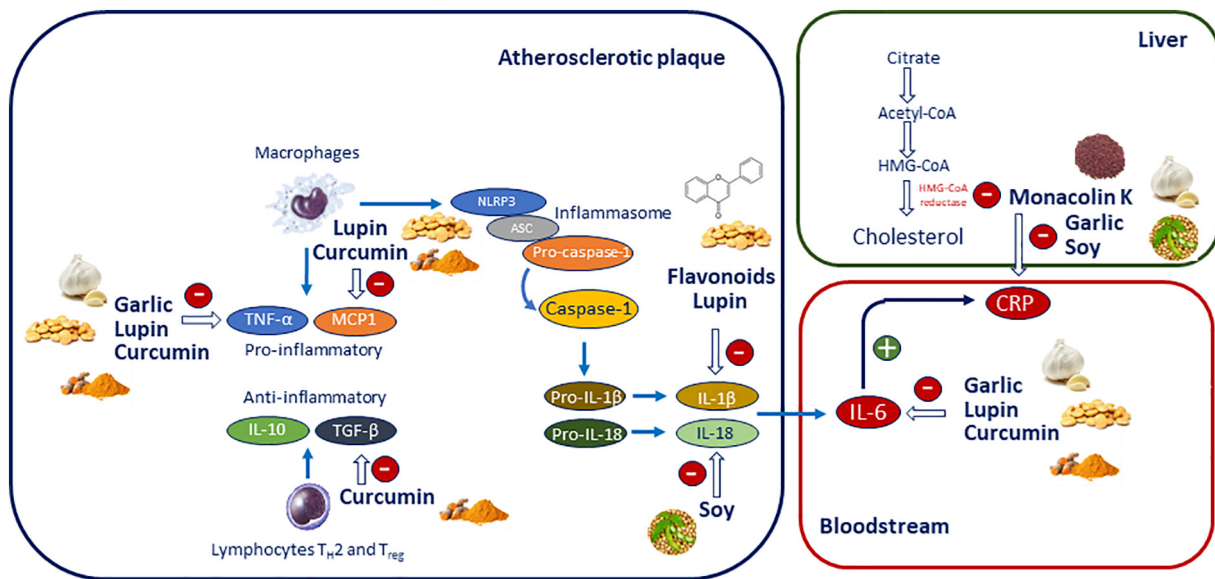


Fig. 2. Basic mechanism for the anti-inflammatory effect of absorbable agents.

Accumulation of cholesterol in the atherosclerotic plaque determines the recruitment of macrophages and the activation of the inflammasome system. NLRP3 induces caspase-1 activation which, in turn, cleaves pro-IL-1 β and pro-IL-18 to their active counterparts that induce IL-6. In the liver, IL-6 induces CRP synthesis, a clinically proven biomarker of inflammatory status and cardiovascular risk. The effect of different nutraceuticals on pro-inflammatory and anti-inflammatory mediators are depicted.

Abbreviations: C-reactive protein (CRP); Interleukin (IL); β -Hydroxy β -methylglutaryl-CoA (HMG-CoA); NACHT-, LRR- and pyrin domain-containing 3 (NLRP3).

More recently, potential up-regulation of mir-126, leading to inhibition of PI3K/AKT and JAK2/STAT5 signalling pathways, has been reported.⁸⁵ These anti-inflammatory actions have been exploited to ameliorate symptoms and reduce the burden of clinical inflammation in several diseases (e.g., inflammatory bowel disease, psoriasis, etc.); these properties of curcumin are also currently under investigation in a variety of other clinical conditions in the ongoing studies.^{84,86,87} A significant reduction of circulating IL-6 (standardized mean difference [SMD] -2.08) and CRP levels (SMD -0.65) was reported in a recent meta-analysis of 15 RCTs.⁸⁸ A previous meta-analysis of 6 trials testing the impact of curcuminoids on circulating CRP revealed that the overall significant anti-inflammatory effect of curcuminoids was dependent on the bioavailability of the different preparations.⁸⁹

The bioavailability of curcumin is low following oral use, and a number of reports have investigated if the use of novel formulations and absorption enhancers could boost the pharmacological effects.⁹⁰ Recently, a phospholipid-curcumin complex was found to be better absorbed and to provide higher benefit at a 250 mg/day dosage (equivalent to 50 mg of curcumin) in conditions such as non-alcoholic fatty liver disease (NAFLD). In a double-blind study, positive changes in the liver proteome were reported after 8 weeks of administration.⁹⁰ Moreover, several studies have shown that co-administration of curcumin with the alkaloid piperine might be effective in enhancing the bioavailability of the former; the anti-inflammatory effects of this combination has been reported in RCTs.⁹¹ A prodrug hypothesis has been very recently proposed in order to explain the anti-inflammatory activity of curcumin in the absence of adequate bioavailability.⁹² Curcumin can undergo extensive glucuronidation in plasma and curcumin glucuronide may act as an inflammation responsive natural prodrug, being later converted back to curcumin in inflamed target tissues. By this mechanism, curcumin would act as a direct anti-inflammatory and potentially antitumoral agent⁹² (Table 3, Fig. 2).

Bergamot is the common name of the fruit *Citrus bergami*, Risso. It differs from other Citrus fruits in composition and richness in flavonoids. Bergamot essential oil (BEO) and bergamot juice (BJ) contain up to 93–96% volatile compounds such as monoterpenes (mainly limonene) and 4–7% nonvolatile compounds, such as pigments, waxes, coumarins, and psoralens.⁹³ Some Bergamot fractions were found to have statin-like

actions, inhibiting HMG-CoA reductase,⁹⁴ indicating that bergamot (generally at the dose of 1000 mg/day) can lower total and LDL-cholesterol in patients, in addition to reducing oxidized LDL.⁹⁵ Its lipid-lowering potential and safety has led to the recommendations of bergamot in statin intolerant patients (IIa B) in the ILEP Position Paper in 2018.⁹⁶

The anti-inflammatory activity of bergamot might be associated with a reduction in pro-inflammatory cytokines,⁹⁷ the mechanism occurring *via* sirtuin-1 (SIRT-1)-mediated NF- κ B inhibition in THP1 monocytes. An *in vitro* protective effect of bergamot peel extract on endothelial cells exposed to tumor TNF- α was found to be associated with reduced intracellular levels of malondialdehyde/4-hydroxynonenal and raised oxidized glutathione and superoxide dismutase activities.⁹⁸ The anti-inflammatory activity of bergamot could be of potential clinical interest, as reported in experimental *periodontal disease*, where bergamot reduced tissue injury and several markers of gingival inflammation, including nuclear NF- κ B translocation, cytokine expression, myeloperoxidase activity and adhesion molecules such as ICAM and P-selectin.⁹⁹ In inflammatory bowel disease, administration of bergamot was found to reduce the release of pro-inflammatory cytokines and decrease apoptosis, with an increase of antiapoptotic BCL-2 in a model of ischemia-reperfusion injury.¹⁰⁰ Bergamot appears not to exert any serious adverse effects, and interest in the potential use in dental and cardiological patients remains active, however more clinical data on the potential anti-inflammatory activities of bergamot is still necessary (Table 3, Fig. 2).

Garlic (*Allium sativum*) has been traditionally believed to be endowed with numerous beneficial properties, including lipid-lowering and anti-hypertensive actions. While many of these actions have not been definitively confirmed, a number of studies have reported potential activity of garlic in allergic conditions and dermatitis.¹³ Garlic contains the non-protein amino acid allicin, characterized by the content of hydrogen sulphide (H₂S), a potential nitric oxide (NO) agonist.¹³ Recently a large meta-analysis of 16 RCTs¹⁰¹ reported that garlic doses ranging from 1200 to 3600 mg/d for a duration of 2–52 weeks significantly reduced CRP (−0.61 mg/L), IL-6 (0.73 ng/L) and TNF- α (−0.26 ng/L), with no activity on adiponectin and leptin, thus indicating that a potential mechanism on inflammatory and CVD disorders needs still to be evaluated. A further activity of potential clinical interest is the antagonism of the

pro-inflammatory adipocytokines resistin and TNF- α by garlic supplementation leading to reduced severity of pain in overweight and obese women with knee osteoarthritis in a RCT¹⁰² (Table 3, Fig. 2).

Berberine is a quinolone alkaloid found in various medicinal plants, including *Coptis chinensis* and *Berberis aristata*. In addition to the many traditional activities described in the old literature, recent years have provided evidence of significant stimulatory activity on LDL receptors (with the class IA in the ILEP recommendations).^{13,103} This experimental observation was later supported by numerous studies in hyperlipidemia and diabetes. Berberine also appears to have a unique mechanism, i.e., that of reducing peripheral branched-chain amino acids (BCAA); by this mechanism, it can improve insulin resistance in experimental models and in humans.¹⁰⁴ This mechanism may be potentially associated with direct anti-inflammatory effects described in animal models such as *apo E*^{-/-} mice,¹⁰⁵ thus suggesting the potential to reduce atheroma plaque size, vulnerability, inflammation and oxidative stress. Unfortunately, the bioavailability of berberine is poor, but clinical use in European countries in combination with red yeast rice (RYR) has found wide support.¹⁰⁶ An unexpected activity of berberine was recently observed in a model of experimental NAFLD, i.e. the reduction of the inflammatory response by way of SIRT3-mediated long-chain acyl CoA dehydrogenase (LCAD) deacetylation.¹⁰⁶ In NAFLD induced by a high-fat diet in mice, pro-inflammatory cytokines (CCL2, TNF- α) are increased, as is the infiltration of inflammatory cells (CCR2), hepatic mRNA and levels of angiopoietin-like 2 (Angptl2), NF- κ B and forkhead box protein O1 (Foxo1). Following berberine treatment, liver tissue pathology, biochemical data, and the Angptl2 pathway-related genes are significantly ameliorated.¹⁰⁷

Despite a lipid-lowering potential and available experimental studies with berberine on its antiinflammatory properties, there are still limited clinical data on the potential role of berberine on the inflammatory parameters. The meta-analysis of 5 RCTs showed that serum levels of CRP were significantly decreased after berberine supplementation (-0.64 mg/L). Based on these results, the authors concluded that especially CVD and diabetic patients are two important groups, which might benefit from berberine supplementation, however further well-designed, longer studies with larger samples are needed to ascertain the effects of berberine on chronic inflammation¹⁰⁸ (Table 3, Fig. 2).

RYR is a prodrug derived from a contaminant of rice containing the yeast *Monascus purpureus*, from which statins were originally extracted. RYR contains monacolin K, chemically identical to lovastatin, in concentrations around 2%. A number of studies have evaluated RYR by itself or as purified derivatives enriched with monacolin K. The cholesterol-lowering activity has been well described and is comparable with that of lovastatin.¹⁰⁹ In the last several years, there has been a substantial debate on RYR safety, however, recent reports, including post-marketing nutrivicilance reports (based on data from 2.3 million consumers), clearly confirmed its safety, even in patients with statin intolerance.^{110–112}

A raw extract of RYR, xuezhikang, given in doses of 1200–1400 mg/day, was associated with a 45% reduction in CHD events over 4.5 years, as well as significant reductions in CVD and total mortality in a large controlled secondary prevention study.¹¹³ In CHD patients, xuezhikang (1200 mg/day) given for 6 weeks also led to a 50% reduction in fasting hsCRP reduction compared with placebo. This decrement was correlated with improved preprandial and postprandial flow-mediated dilatation (FMD), an index of endothelial function.¹¹⁴ Similar conclusions were reached when patients with stable angina were considered. After 14 days, xuezhikang (1200 or 2400 mg/day) reduced the levels of hsCRP by roughly 28% from baseline values, an effect irrespective of the dose.¹¹⁵

A number of specifically targeted studies of RYR in inflammation have been published recently, potentially indicating an improvement of endothelial dysfunction. Monacolin K promotes and stabilizes the expression of endothelial nitric oxide synthase (eNOS) and uncouples tetrahydrobiopterin (BH4).¹¹⁶ The anti-inflammatory mechanism of RYR is quite similar to that of statins, i.e., suppression of NF- κ B binding

to cells and inhibition of the IP3K/AKT/nGOR pathway and histone deacetylase 1.¹¹⁷ This may lead to the inhibition of mitogen-activated protein kinases (MAPKs) participating in inflammation through various subfamilies (JNK, ERK 1/2 and p38 kinase). Inflammation occurring atherosclerosis induced by a high-fat diet is suppressed by RYR via the blocking of MAPK signalling pathways.¹¹⁸ RYR may thus reduce the expression of pro-inflammatory mediators through the PK signalling pathway and inhibited NO release, thereby ameliorating inflammation-linked diseases mediated by excessive and/or prolonged activation of immune cells¹¹⁹ (Fig. 2). In *in vitro* conditions RYR reduced TNF α by down-regulating the NF- κ B activity and reducing the intracellular production of reactive oxygen species (ROS) in aortic smooth muscle cells (SMC),¹²⁰ thus supporting the conclusion that the anti-inflammatory effect may be similar to that of statins and may be of potential benefit in CVD prevention^{121,122} (Table 3).

Dietary plant proteins

Dietary plant proteins have been associated, in a number of recent epidemiological studies, with a significant protective effect against CVD.¹²³ Dietary studies with the use of specific proteins have largely focused on soy and lupin. The use of soy proteins for the treatment of hypercholesterolemia dates back several decades.^{124,125} In recent years, this type of dietary approach to severe hypercholesterolemia has been utilized to a far lesser extent, mainly because of the commercial availability of statins, which have dramatic activity on upregulating the LDL receptor on hepatocytes.

Among the consequences of frequent use of this diet among normocholesterolemic or moderately hypercholesterolemic individuals, a number of erroneous conclusions were drawn. The first is that soy proteins do not possess a hypocholesterolemic activity: this was contradicted by the observation that soy proteins and components such as the 7S globulin markedly activate LDL-R expression in animals¹²⁶ and in patients with familial hypercholesterolemia.¹²⁷ The second erroneous conclusion is that other components such as phytoestrogens present to a variable extent in commercial soy preparations but absent, e.g. in lupin, may be responsible. Phytoestrogens do not exert any significant hypocholesterolemic activity.^{128,129}

The anti-inflammatory activity of soy and lupin proteins is again likely dependent in both cases on the protein component,¹³⁰ but the presence in soy of other non-protein moieties may perhaps contribute to some extent to the anti-inflammatory activity without having any effect on cholesterol.

Soy proteins

Dietary soy proteins are available as a mixture of proteins and peptides, with additional components, including fibers and phytoestrogens. Phytoestrogens may be of some benefit in the relief of symptoms in post-menopausal women. However, the results of the studies are not conclusive.¹³¹ Some clinical benefit on inflammatory markers was reported in women with metabolic syndrome.¹³² In this last study, consumption of soy-nut was compared with that of soy proteins and red meat. Soy-nut exerted a clearly better anti-inflammatory activity compared with soy proteins and red meat. In particular, IL-18 was reduced by -9.2% by soy-nuts compared with meat, but soy proteins had no activity. With respect to CRP, the difference from the red meat diet was significant (-8.9%) on the soy-nut diet and -1.6% on the soy protein diet.¹³² While in this study, phytoestrogen intake may have played an important role, more recent studies have been focused on the protein components themselves. Detailed investigations have described bioactive anti-inflammatory peptides (BAPs) released from dietary proteins by enzymatic digestion in the intestine. BAPs, at concentrations of 200–1000 μ M, inhibit inflammation by the MAPK or NFK- β pathways.¹³³ This type of antagonism to inflammatory cytokine expression can also be exerted by soybean derived dipeptides and tripeptides.¹³⁴

Contradictory and inconclusive findings have been reported in two meta-analyses evaluating the effect of soy supplementation on inflammatory biomarkers. The first meta-analysis comprising 36 studies published before December 2016 showed a non-significant 0.19 mg/dL reduction in the levels of hsCRP after consumption of soy products.¹³⁵ Subgroup analysis highlighted that this effect was mainly driven by natural soy products in comparison with other sources of isoflavones, being the levels of the latter significantly correlated with serum hsCRP.¹³⁵ A second meta-analysis comprising 51 RCT reported that supplementation with soy products led to a significant reduction of hsCRP (-0.27 mg/L; 95% CI -0.51 , -0.02) but not IL-6 and TNF- α . However, the effect became significant when studies with a long-term design (≥ 12 weeks) and low dose isoflavone (< 100 mg/day) were chosen.¹³⁶

The soy diet has been shown to result in remarkably reduced colon inflammation in pigs with dextran-sulphate induced colitis.¹³⁴ Furthermore, clear evidence has now been provided that these small molecules can be transported from the intestine into the bloodstream of humans or animals by the peptide transporter (hPepT1) system,¹³⁷ thus indicating the potential for soybean proteins to affect generalized inflammatory diseases such as atherosclerosis and hypertension.¹³⁸ The potential of soy protein diets to exert lipid-lowering effects in hypercholesterolemic individuals, and to affect inflammation, may lead to advances in the prevention of ASCVD and the development of protein or peptide fractions with improved activity (Table 3, Fig. 2).

Lupin proteins

Proteins from white lupin seed are essentially phytoestrogen free and exert a similar activity to soy on cholesterolemia in rodents.^{139,140} This occurs via stimulation of the activity of LDL-R. Proteins from lupin have been investigated to a lesser extent than soy in the clinical treatment of hypercholesterolemia, but results have been encouraging.¹⁴¹ Some lupin proteins have been demonstrated to have anti-inflammatory activity. The most active is γ -conglutin, a small protein that is associated with improvements in insulin resistance *in vitro*.¹⁴² This protein has been extensively studied for a potential hypoglycemic activity,¹⁴³ but in addition, it has been shown to have a potential role in the regulation of blood pressure by inhibiting the activity of angiotensin converting enzyme (ACE).¹⁴⁴ Peptides with inhibitory activity against ACE can be obtained by direct enzymatic hydrolysis of lupin.¹⁴⁵ These peptides appear to provide a range of potential activities besides those on lipids and blood pressure. Specifically, the anti-inflammatory activity,¹⁴⁶ in addition to the lipid-lowering mechanism, may offer an important tool for CVD prevention. Lupin peptides were recently investigated for their anti-inflammatory activity on RAW264.7 cells (cell line origin: mouse monocyte macrophage).¹⁴⁷ Among peptides isolated from the gastroduodenal digests of extruded lupin, the lupine peptide monomer IQDKEGIPPDQQR was the most promising, significantly inhibiting lipoprotein polysaccharide (LPS) induced activation of TNF- α , IL-6, IL-1 β and MCP-1 production by 40–50% at a concentration of 10 μ M.¹⁴⁷ Lupin proteins appears not to exert any serious adverse effects, however clinical data on their potential anti-inflammatory activities is mandatory (Table 3, Fig. 2).

Conclusions

Increased recognition of the problem of residual CVD risk in optimally drug-treated patients has led to more intensive evaluation of non-drug approaches, in particular nutraceuticals. Most available data relates to the effect of nutraceuticals on selected inflammatory parameters, and we must strongly emphasize the fact that nutraceuticals cannot replace pharmacological treatment. Nevertheless, they might be useful, especially given the currently limited range of options for therapeutic antiinflammatory agents, particularly at the present time when optimal therapy is necessary during the COVID-19 pandemic.

Indeed, as has been reviewed elsewhere,¹² not all recent drug-based anti-inflammatory interventions aimed at reducing CVD burden have been successful. While in the CANTOS (Canakinumab Antiinflammatory Thrombosis Outcome Study) trial, the use of canakinumab (anti-IL1 β) led to a 15% reduction in CVD events, and a similar outcome occurred in the COLCOT (Colchicine Cardiovascular Outcomes Trial) study with colchicine (-13%), a neutral effect was described in the CIRT (Cardiovascular Inflammation Reduction Trial) study with methotrexate (HR 1.01; 95% CI 0.82–1.25). Furthermore, in an Australian trial enrolling patients with acute coronary syndromes, the addition of colchicine to standard medical therapy did not significantly affect CVD outcomes at 12 months and was associated with a higher rate of mortality.¹⁴⁸ Irrespective, of these findings, none of these drugs is yet available on the market to treat inflammatory-linked CVD residual risk. Only colchicine seems likely to enter clinical practice in the near future, and only in patients with strictly limited indications.^{149,150}

This detailed overview of nutraceuticals addresses their effects on inflammatory parameters and offers a promising insight into the role of natural molecules or functional foods with the potential to reduce the inflammatory burden associated with CVD. These are the first recommendations that provide a clear message on the nutraceuticals with the potential to reduce inflammation. These generally well-tolerated products are increasingly used¹¹² in the community and may provide, due to their multiple properties (lipid-lowering, anti-inflammatory, anti-oxidant, hypoglycemic, etc.), some benefits in conditions of raised CVD risk, which is not fully addressed by currently available pharmacological treatments.

In addition to the effectiveness of selected nutraceuticals to reduce inflammatory parameters levels, equally important (despite currently insufficient data), is that these therapies appear to be safe and well tolerated. However, further studies in individuals with inflammatory conditions, especially in those with residual CVD risk due to inflammation (with a suitably large group of patients and longer follow-up), are still necessary to confirm the effectiveness and safety of nutraceuticals (at a specific dosage), to prove that they maintain their efficacy in the long-term, as well as to answer the question of whether these therapies might have a positive effect on CVD outcomes.

Declaration of interest

Peter E. Penson owns four shares in AstraZeneca PLC and has received honoraria and/or travel reimbursement for events sponsored by AKCEA, Amgen, AMRYT, Link Medical, Mylan, Napp, Sanofi; G.B. John Mancini - grants and honoraria: Amgen, Sanofi, HLS Therapeutics, Esperion, Novartis; Patrick M. Moriarty - grants and honoraria: Academic CME, Akcea, Amarin, Amgen, FH Foundation, Ionis, Kaneka, Kowa, Lilly, NLA, Regeneron, RegenXBio, Renew, Sanofi, HLS Therapeutics, Esperion, Novartis; Dimitri P. Mikhailidis has given talks, acted as a consultant or attended conferences sponsored by Amgen and Novo Nordisk; Maciej Banach: speakers bureau: Amgen, Herbapol, Kogen, KRKA, Polpharma, Mylan/Viatis, Novartis, Novo-Nordisk, Sanofi-Aventis, Teva, Zentiva; consultant to Abbott Vascular, Amgen, Daichii Sankyo, Esperion, FreiaPharmaceuticals, Novartis, Polfarmex, Sanofi-Aventis; Grants from Amgen, Mylan/Viatis, Sanofi and Valeant; all other authors have no conflict of interest.

Acknowledgment

Funding: This position paper was written independently; no company or institution supported it financially. No professional writer was involved in the preparation of this position paper.

References

1. Quispe R, Michos ED, Martin SS, et al. High-sensitivity C-reactive protein discordance with atherogenic lipid measures and incidence of atherosclerotic

- cardiovascular disease in primary prevention: the ARIC study. *J Am Heart Assoc* 2020;9(3), e013600.
2. Penson PE, Long DL, Howard G, et al. Associations between very low concentrations of low density lipoprotein cholesterol, high sensitivity C-reactive protein, and health outcomes in the Reasons for Geographical and Racial Differences in Stroke (REGARDS) study. *Eur Heart J* 2018;39(40):3641–3653.
 3. Yvan-Charvet L, Bonacina F, Guinamard RR, Norata GD. Immunometabolic function of cholesterol in cardiovascular disease and beyond. *Cardiovasc Res* 2019;115(9):1393–1407.
 4. Libby P, Ridker PM. Inflammation and atherosclerosis: role of C-reactive protein in risk assessment. *Am J Med* 2004;116(Suppl 6A):9S–16S.
 5. Ridker PM, MacFadyen JG, Glynn RJ, Bradwin G, Hasan AA, Rifai N. Comparison of interleukin-6, C-reactive protein, and low-density lipoprotein cholesterol as biomarkers of residual risk in contemporary practice: secondary analyses from the Cardiovascular Inflammation Reduction Trial. *Eur Heart J* 2020;41(31):2952–2961.
 6. Ridker PM. From CANTOS to CIRT to COLCOT to clinic: will all atherosclerosis patients soon be treated with combination lipid-lowering and inflammation-inhibiting agents? *Circulation* 2020;141(10):787–789.
 7. Duewell P, Kono H, Rayner KJ, et al. NLRP3 inflammasomes are required for atherogenesis and activated by cholesterol crystals. *Nature* 2010;464(7293):1357–1361.
 8. Mangan MSJ, Olhava EJ, Roush WR, Seidel HM, Glick GD, Latz E. Targeting the NLRP3 inflammasome in inflammatory diseases. *Nat Rev Drug Discov* 2018;17(9):688.
 9. Fadini GP, Agostini C, Avogaro A. Endothelial progenitor cells and erectile dysfunction. *Eur Heart J* 2007;28(5):639–640. [author reply 40].
 10. Jaiswal S, Natarajan P, Silver AJ, et al. Clonal hematopoiesis and risk of atherosclerotic cardiovascular disease. *N Engl J Med* 2017;377(2):111–121.
 11. Koushki K, Shahbaz SK, Mashayekhi K, et al. Anti-inflammatory action of statins in cardiovascular disease: the role of inflammasome and toll-like receptor pathways. *Clin Rev Allergy Immunol* 2021;60(2):175–199.
 12. Ruscica M, Corsini A, Ferri N, Banach M, Sirtori CR. Clinical approach to the inflammatory etiology of cardiovascular diseases. *Pharmacol Res* 2020;159:104916.
 13. Cicero AFG, Colletti A, Bajraktari G, et al. Lipid-lowering nutraceuticals in clinical practice: position paper from an international lipid expert panel. *Nutr Rev* 2017;75(9):731–767.
 14. Mazidi M, Kengne AP, Mikhailidis DP, Cicero AF, Banach M. Effects of selected dietary constituents on high-sensitivity C-reactive protein levels in U.S. adults. *Ann Med* 2018;50(1):1–6.
 15. Dietary fat and its relation to heart attacks and strokes. Report by the Central Committee for Medical and Community Program of the American Heart Association. *JAMA* 1961;175:389–391.
 16. Ramsden CE, Zamora D, Leelarthaepin B, et al. Use of dietary linoleic acid for secondary prevention of coronary heart disease and death: evaluation of recovered data from the Sydney Diet Heart Study and updated meta-analysis. *BMJ* 2013;346, e8707.
 17. Innes JK, Calder PC. Omega-6 fatty acids and inflammation. *Prostaglandins Leukot Essent Fatty Acids* 2018;132:41–48.
 18. Korotkova M, Lundberg IE. The skeletal muscle arachidonic acid cascade in health and inflammatory disease. *Nat Rev Rheumatol* 2014;10(5):295–303.
 19. Rett BS, Whelan J. Increasing dietary linoleic acid does not increase tissue arachidonic acid content in adults consuming Western-type diets: a systematic review. *Nutr Metab (Lond)* 2011;8:36.
 20. Masoodi M, Pearl DS, Eiden M, et al. Altered colonic mucosal Polyunsaturated Fatty Acid (PUFA) derived lipid mediators in ulcerative colitis: new insight into relationship with disease activity and pathophysiology. *PLoS One* 2013;8(10), e76532.
 21. Pischon T, Hankinson SE, Hotamisligil GS, Rifai N, Willett WC, Rimm EB. Habitual dietary intake of n-3 and n-6 fatty acids in relation to inflammatory markers among US men and women. *Circulation* 2003;108(2):155–160.
 22. Ferrucci L, Cherubini A, Bandinelli S, et al. Relationship of plasma polyunsaturated fatty acids to circulating inflammatory markers. *J Clin Endocrinol Metab* 2006;91(2):439–446.
 23. Bjermo H, Darnerud PO, Lignell S, et al. Fish intake and breastfeeding time are associated with serum concentrations of organochlorines in a Swedish population. *Environ Int* 2013;51:88–96.
 24. Chan JK, McDonald BE, Gerrard JM, Bruce VM, Weaver BJ, Holub BJ. Effect of dietary alpha-linolenic acid and its ratio to linoleic acid on platelet and plasma fatty acids and thrombogenesis. *Lipids* 1993;28(9):811–817.
 25. Marklund M, Wu JHY, Imamura F, et al. Biomarkers of dietary Omega-6 fatty acids and incident cardiovascular disease and mortality. *Circulation* 2019;139(21):2422–2436.
 26. Mazidi M, Shekoohi N, Katsiki N, Banach M, The Lipid and Blood Pressure Meta-Analysis Collaboration (LBPAC) Group. Omega-6 fatty acids and risk of cardiovascular disease: Insights from systematic review and meta-analysis of randomized controlled trials and a mendelian randomization study. *Arch Med Sci* 2021. <https://doi.org/10.5114/aoms/136070>.
 27. Salas-Salvado J, Marquez-Sandoval F, Bullo M. Conjugated linoleic acid intake in humans: a systematic review focusing on its effect on body composition, glucose, and lipid metabolism. *Crit Rev Food Sci Nutr* 2006;46(6):479–488.
 28. Murru E, Carta G, Manca C, et al. Conjugated linoleic acid and brain metabolism: a possible anti-neuroinflammatory role mediated by PPARalpha activation. *Front Pharmacol* 2020;11:587140.
 29. Calder PC. Omega-3 polyunsaturated fatty acids and inflammatory processes: nutrition or pharmacology? *Br J Clin Pharmacol* 2013;75(3):645–662.
 30. Calder PC. Marine omega-3 fatty acids and inflammatory processes: effects, mechanisms and clinical relevance. *Biochim Biophys Acta* 2015;1851(4):469–484.
 31. Bannenberg G, Serhan CN. Specialized pro-resolving lipid mediators in the inflammatory response: an update. *Biochim Biophys Acta* 2010;1801(12):1260–1273.
 32. Weylandt KH. Docosapentaenoic acid derived metabolites and mediators – the new world of lipid mediator medicine in a nutshell. *Eur J Pharmacol* 2016;785:108–115.
 33. Calder PC. Omega-3 fatty acids and inflammatory processes: from molecules to man. *Biochem Soc Trans* 2017;45(5):1105–1115.
 34. Healy DA, Wallace FA, Miles EA, Calder PC, Newsholm P. Effect of low-to-moderate amounts of dietary fish oil on neutrophil lipid composition and function. *Lipids* 2000;35(7):763–768.
 35. Bhaskar S, Sinha A, Banach M, et al. Cytokine storm in COVID-19-immunopathological mechanisms, clinical considerations, and therapeutic approaches: the REPROGRAM Consortium Position Paper. *Front Immunol* 2020 Jul 10;11:1648.
 36. Weatherill AR, Lee JY, Zhao L, Lemay DG, Youn HS, Hwang DH. Saturated and polyunsaturated fatty acids reciprocally modulate dendritic cell functions mediated through TLR4. *J Immunol* 2005;174(9):5390–5397.
 37. Tan A, Sullenbarger B, Prakash R, McDaniel JC. Supplementation with eicosapentaenoic acid and docosahexaenoic acid reduces high levels of circulating proinflammatory cytokines in aging adults: a randomized, controlled study. *Prostaglandins Leukot Essent Fatty Acids* 2018;132:23–29.
 38. McDaniel JC, Rausch J, Tan A. Impact of omega-3 fatty acid oral therapy on healing of chronic venous leg ulcers in older adults: study protocol for a randomized controlled single-center trial. *Trials* 2020;21(1):93.
 39. Allaire J, Couture P, Leclerc M, et al. A randomized, crossover, head-to-head comparison of eicosapentaenoic acid and docosahexaenoic acid supplementation to reduce inflammation markers in men and women: the Comparing EPA to DHA (CompareD) Study. *Am J Clin Nutr* 2016;104(2):280–287.
 40. Pisaniello AD, Psaltis PJ, King PM, et al. Omega-3 fatty acids ameliorate vascular inflammation: a rationale for their atheroprotective effects. *Atherosclerosis* 2021;324:27–37.
 41. Takahashi M, Myojo M, Watanabe A, et al. Effect of purified eicosapentaenoic acid on red cell distribution width in patients with ischemic heart disease. *Heart Vessels* 2015;30(5):587–594.
 42. Meital LT, Windsor MT, Ramirez Jewell RML, et al. n-3 PUFAs improve erythrocyte fatty acid profile in patients with small AAA: a randomized controlled trial. *J Lipid Res* 2019;60(6):1154–1163.
 43. Bhatt DL, Steg PG, Miller M, et al. Cardiovascular risk reduction with Icosapent ethyl for hypertriglyceridemia. *N Engl J Med* 2019;380(1):11–22.
 44. Yokoyama M, Origasa H, Matsuzaki M, et al. Effects of eicosapentaenoic acid on major coronary events in hypercholesterolaemic patients (JELIS): a randomised open-label, blinded endpoint analysis. *Lancet* 2007;369(9567):1090–1098.
 45. Mazidi M, Mikhailidis DP, Banach M. Omega-3 fatty acids and risk of cardiovascular disease: systematic review and meta-analysis of randomized controlled trials with 127,447 individuals and a Mendelian randomization study. *Circulation* 2019;140(14):e965–e1011.
 46. Nicholls SJ, Lincoff AM, Garcia M, et al. Effect of high-dose Omega-3 fatty acids vs corn oil on major adverse cardiovascular events in patients at high cardiovascular risk: the STRENGTH randomized clinical trial. *JAMA* 2020;324(22):2268–2280.
 47. Kastelein JJ, Maki KC, Susekov A, et al. Omega-3 free fatty acids for the treatment of severe hypertriglyceridemia: the EpanoVa for Lowering Very high triglycerides (EVOLVE) trial. *J Clin Lipidol* 2014;8(1):94–106.
 48. Kastelein JJP, Stroes ESG. FISHing for the miracle of eicosapentaenoic acid. *N Engl J Med* 2019;380(1):89–90.
 49. Sirtori CR, Yamashita S, Greco MF, Corsini A, Watts GF, Ruscica M. Recent advances in synthetic pharmacotherapies for dyslipidaemias. *Eur J Prev Cardiol* 2020;27(15):1576–1596.
 50. Penson PE, Banach M. The role of nutraceuticals in the optimization of lipid-lowering therapy in high-risk patients with dyslipidaemia. *Curr Atheroscler Rep* 2020;22(11):67.
 51. Group ASC, Bowman L, Mafham M, et al. Effects of n-3 fatty acid supplements in diabetes mellitus. *N Engl J Med* 2018;379(16):1540–1550.
 52. Manson JE, Cook NR, Lee IM, et al. Marine n-3 fatty acids and prevention of cardiovascular disease and cancer. *N Engl J Med* 2019;380(1):23–32.
 53. Bernasconi AA, Wiest MM, Lavie CJ, Milani RV, Laukkanen JA. Effect of Omega-3 dosage on cardiovascular outcomes: an updated meta-analysis and meta-regression of interventional trials. *Mayo Clin Proc* 2021;96(2):304–313.
 54. Bernasconi AA, Lavie CJ, Milani RV, Laukkanen JA. Omega-3 benefits remain strong post-STRENGTH. *Mayo Clin Proc* 2021;96(5):1371–1372.
 55. Elagizi A, Lavie CJ, O'Keefe E, Marshall K, O'Keefe JH, Milani RV. An update on Omega-3 polyunsaturated fatty acids and cardiovascular health. *Nutrients* 2021;13(1):204.
 56. O'Keefe EL, Harris WS, DiNicolantonio JJ, et al. Sea change for marine omega-3s: randomized trials show fish oil reduces cardiovascular events. *Mayo Clin Proc* 2019;94(12):2524–2533.
 57. Jiao J, Xu JY, Zhang W, Han S, Qin LQ. Effect of dietary fiber on circulating C-reactive protein in overweight and obese adults: a meta-analysis of randomized controlled trials. *Int J Food Sci Nutr* 2015;66(1):114–119.
 58. Morel FB, Dai Q, Ni J, Thomas D, Parnet P, Fanca-Berthon P. Alpha-galacto-oligosaccharides dose-dependently reduce appetite and decrease inflammation in overweight adults. *J Nutr* 2015;145(9):2052–2059.
 59. Athyros VG, Kakafika AI, Papageorgiou AA, et al. Effect of a plant stanol ester-containing spread, placebo spread, or Mediterranean diet on estimated cardiovascular risk and lipid, inflammatory and haemostatic factors. *Nutr Metab Cardiovasc Dis* 2011;21(3):213–221.
 60. Gylling H, Plat J, Turley S, et al. Plant sterols and plant stanols in the management of dyslipidaemia and prevention of cardiovascular disease. *Atherosclerosis* 2014;232(2):346–360.

61. Helgadóttir A, Thorleifsson G, Alexandersson KF, et al. Genetic variability in the absorption of dietary sterols affects the risk of coronary artery disease. *Eur Heart J* 2020;41(28):2618–2628.
62. Ruuth M, Aikas L, Tigistu-Sahle F, et al. Plant Stanol esters reduce LDL (low-density lipoprotein) aggregation by altering LDL surface lipids: the BLOOD FLOW randomized intervention study. *Arterioscler Thromb Vasc Biol* 2020;40(9):2310–2321.
63. Ruuth M, Janssen LGM, Aikas L, et al. LDL aggregation susceptibility is higher in healthy south Asian compared with white Caucasian men. *J Clin Lipidol* 2019;13(6):910–9 e2.
64. Klaver FA, van der Meer R. The assumed assimilation of cholesterol by *Lactobacilli* and *Bifidobacterium bifidum* is due to their bile salt-deconjugating activity. *Appl Environ Microbiol* 1993;59(4):1120–1124.
65. Shimizu M, Hashiguchi M, Shiga T, Tamura HO, Mochizuki M. Meta-analysis: effects of probiotic supplementation on lipid profiles in normal to mildly hypercholesterolemic individuals. *PLoS One* 2015;10(10):e0139795.
66. Wang Z, Klipfell E, Bennett BJ, et al. Gut flora metabolism of phosphatidylcholine promotes cardiovascular disease. *Nature* 2011;472(7341):57–63.
67. Forsberg A, Abrahamsson TR, Nilsson L, Ernerudh J, Duchon K, Jenmalm MC. Changes in peripheral immune populations during pregnancy and modulation by probiotics and omega-3 fatty acids. *Sci Rep* 2020;10(1):18723.
68. Wang H, Zhou C, Huang J, Kuai X, Shao X. The potential therapeutic role of *Lactobacillus reuteri* for treatment of inflammatory bowel disease. *Am J Transl Res* 2020;12(5):1569–1583.
69. Moss JWE, Williams JO, Ramji DP. Nutraceuticals as therapeutic agents for atherosclerosis. *Biochim Biophys Acta Mol Basis Dis* 2018;1864(5 Pt A):1562–1572.
70. Al-Dashti YA, Holt RR, Stebbins CL, Keen CL, Hackman RM. Dietary flavanols: a review of select effects on vascular function, blood pressure, and exercise performance. *J Am Coll Nutr* 2018;37(7):553–567.
71. Kang SW, Hahn S, Kim JK, Yang SM, Park BJ, Chul Lee S. Oligomerized lychee fruit extract (OLFE) and a mixture of vitamin C and vitamin E for endurance capacity in a double blind randomized controlled trial. *J Clin Biochem Nutr* 2012;50(2):106–113.
72. Giglio RV, Patti AM, Cicero AFG, et al. Polyphenols: potential use in the prevention and treatment of cardiovascular diseases. *Curr Pharm Des* 2018;24(2):239–258.
73. Grassi D, Desideri G, Necozione S, et al. Blood pressure is reduced and insulin sensitivity increased in glucose-intolerant, hypertensive subjects after 15 days of consuming high-polyphenol dark chocolate. *J Nutr* 2008;138(9):1671–1676.
74. Mastroiacovo D, Kwik-Urbe C, Grassi D, et al. Cocoa flavanol consumption improves cognitive function, blood pressure control, and metabolic profile in elderly subjects: the Cocoa, Cognition, and Aging (CoCoA) Study – a randomized controlled trial. *Am J Clin Nutr* 2015;101(3):538–548.
75. Cicero AFG, Fogacci F, Banach M. Botanicals and phytochemicals active on cognitive decline: the clinical evidence. *Pharmacol Res* 2018;130:204–212.
76. Baker LD, Rapp SR, Shumaker SA, et al. Design and baseline characteristics of the cocoa supplement and multivitamin outcomes study for the mind: COSMOS-Mind. *Contemp Clin Trials* 2019;83:57–63.
77. McDermott MM, Criqui MH, Domanchuk K, et al. Cocoa to improve walking performance in older people with peripheral artery disease: the COCOA-PAD pilot randomized clinical trial. *Circ Res* 2020;126(5):589–599.
78. Matsui R, Hamburg NM. Eating chocolate to improve muscle health and walking ability in patients with peripheral artery disease. *Circ Res* 2020;126(5):600–602.
79. Sarria B, Martinez-Lopez S, Sierra-Cinos JL, Garcia-Diz L, Mateos R, Bravo L. Regular consumption of a cocoa product improves the cardiometabolic profile in healthy and moderately hypercholesterolemic adults. *Br J Nutr* 2014;111(1):122–134.
80. Medina-Remon A, Casas R, Trezzserra-Rimbau A, et al. Polyphenol intake from a Mediterranean diet decreases inflammatory biomarkers related to atherosclerosis: a substudy of the PREDIMED trial. *Br J Clin Pharmacol* 2017;83(1):114–128.
81. Panahi Y, Hosseini MS, Khalili N, et al. Effects of curcumin on serum cytokine concentrations in subjects with metabolic syndrome: a post-hoc analysis of a randomized controlled trial. *Biomed Pharmacother* 2016;82:578–582.
82. Ferguson JJA, Stojanovski E, MacDonald-Wicks L, Garg ML. Curcumin potentiates cholesterol-lowering effects of phytosterols in hypercholesterolemic individuals. A randomised controlled trial. *Metabolism* 2018;82:22–35.
83. Sahebkar A, Cicero AFG, Simental-Mendia LE, Aggarwal BB, Gupta SC. Curcumin downregulates human tumor necrosis factor- α levels: a systematic review and meta-analysis of randomized controlled trials. *Pharmacol Res* 2016;107:234–242.
84. Shimizu K, Funamoto M, Sunagawa Y, et al. Anti-inflammatory action of curcumin and its use in the treatment of lifestyle-related diseases. *Eur Cardiol* 2019;14(2):117–122.
85. Li Y, Tian L, Sun D, Yin D. Curcumin ameliorates atherosclerosis through upregulation of miR-126. *J Cell Physiol* 2019;234(11):21049–21059.
86. Hatamipour M, Jamialahmadi T, Ramezani M, et al. Protective effects of curcumin phytosomes against high-fat diet-induced atherosclerosis. *Adv Exp Med Biol* 2021;1308:37–44.
87. Zahedipour F, Hosseini SA, Sathyapalan T, et al. Potential effects of curcumin in the treatment of COVID-19 infection. *Phytother Res* 2020;34(11):2911–2920.
88. Tabrizi R, Vakili S, Akbari M, et al. The effects of curcumin-containing supplements on biomarkers of inflammation and oxidative stress: a systematic review and meta-analysis of randomized controlled trials. *Phytother Res* 2019;33(2):253–262.
89. Sahebkar A. Are curcuminoids effective C-reactive protein-lowering agents in clinical practice? Evidence from a meta-analysis. *Phytother Res* 2014;28(5):633–642.
90. Chashmian S, Mirhafez SR, Dehabe M, Hariri M, Azimi Nezhad M, Nobakht MGBF. A pilot study of the effect of phospholipid curcumin on serum metabolomic profile in patients with non-alcoholic fatty liver disease: a randomized, double-blind, placebo-controlled trial. *Eur J Clin Nutr* 2019;73(9):1224–1235.
91. Panahi Y, Hosseini MS, Khalili N, Naimi E, Majeed M, Sahebkar A. Antioxidant and anti-inflammatory effects of curcuminoid-piperine combination in subjects with metabolic syndrome: a randomized controlled trial and an updated meta-analysis. *Clin Nutr* 2015;34(6):1101–1108.
92. Liu G, Khanna V, Kirtane A, Grill A, Panyam J. Chemopreventive efficacy of oral curcumin: a prodrug hypothesis. *FASEB J* 2019;33(8):9453–9465.
93. Perna S, Spadaccini D, Botteri L, et al. Efficacy of bergamot: from anti-inflammatory and anti-oxidative mechanisms to clinical applications as preventive agent for cardiovascular morbidity, skin diseases, and mood alterations. *Food Sci Nutr* 2019;7(2):369–384.
94. Giglio RV, Patti AM, Nikolic D, et al. The effect of bergamot on dyslipidemia. *Phytomedicine* 2016;23(11):1175–1181.
95. Gliozzi M, Walker R, Muscoli S, et al. Bergamot polyphenolic fraction enhances rosuvastatin-induced effect on LDL-cholesterol, LOX-1 expression and protein kinase B phosphorylation in patients with hyperlipidemia. *Int J Cardiol* 2013;170(2):140–145.
96. Banach M, Patti AM, Giglio RV, et al. International lipid expert panel (ILEP). The role of nutraceuticals in statin intolerant patients. *J Am Coll Cardiol* 2018 Jul 3;72(1):96–118.
97. Ristiano R, Curro M, Cirmi S, et al. Flavonoid fraction of Bergamot juice reduces LPS-induced inflammatory response through SIRT1-mediated NF-kappaB inhibition in THP-1 monocytes. *PLoS One* 2014;9(9):e107431.
98. Trombetta D, Cimino F, Cristani M, et al. In vitro protective effects of two extracts from bergamot peels on human endothelial cells exposed to tumor necrosis factor- α (TNF- α). *J Agric Food Chem* 2010;58(14):8430–8436.
99. Gugliandolo E, Fusco R, D'Amico R, et al. Treatment with a flavonoid-rich fraction of bergamot juice improved lipopolysaccharide-induced periodontitis in rats. *Front Pharmacol* 2018;9:1563.
100. Impellizzeri D, Cordaro M, Campolo M, et al. Anti-inflammatory and antioxidant effects of flavonoid-rich fraction of bergamot juice (BJe) in a mouse model of intestinal ischemia/reperfusion injury. *Front Pharmacol* 2016;7:203.
101. Darooghegi Mofrad M, Milajerdi A, Koohdani F, Surkan PJ, Azadbakht L. Garlic supplementation reduces circulating C-reactive protein, tumor necrosis factor, and interleukin-6 in adults: a systematic review and meta-analysis of randomized controlled trials. *J Nutr* 2019;149(4):605–618.
102. Dehghani S, Alipoor E, Salimzadeh A, et al. The effect of a garlic supplement on the pro-inflammatory adipocytokines, resistin and tumor necrosis factor- α , and on pain severity, in overweight or obese women with knee osteoarthritis. *Phytomedicine* 2018;48:70–75.
103. Kong W, Wei J, Abidi P, et al. Berberine is a novel cholesterol-lowering drug working through a unique mechanism distinct from statins. *Nat Med* 2004;10(12):1344–1351.
104. Yue SJ, Liu J, Wang AT, et al. Berberine alleviates insulin resistance by reducing peripheral branched-chain amino acids. *Am J Physiol Endocrinol Metab* 2019;316(1):E73–E85.
105. Chen J, Cao J, Fang L, et al. Berberine derivatives reduce atherosclerotic plaque size and vulnerability in apoE(–/–) mice. *J Transl Med* 2014;12:326.
106. Xu X, Zhu XP, Bai JY, et al. Berberine alleviates nonalcoholic fatty liver induced by a high-fat diet in mice by activating SIRT3. *FASEB J* 2019;33(6):7289–7300.
107. Lu Z, He B, Chen Z, Yan M, Wu L. Anti-inflammatory activity of berberine in non-alcoholic fatty liver disease via the Angptl2 pathway. *BMC Immunol* 2020;21(1):28.
108. Beba M, Djafarian K, Shab-Bidar S. Effect of Berberine on C-reactive protein: a systematic review and meta-analysis of randomized controlled trials. *Complement Ther Med* 2019;46:81–86.
109. Cicero AFG, Fogacci F, Banach M. Red yeast rice for hypercholesterolemia. *Methodist Debakey Cardiovasc J* 2019 Jul-Sep;15(3):192–199.
110. Cicero AFG, Fogacci F, Zambon A. Red yeast rice for hypercholesterolemia: JACC focus seminar. *J Am Coll Cardiol* 2021;77(5):620–628.
111. Fogacci F, Banach M, Mikhailidis DP, et al. Safety of red yeast rice supplementation: a systematic review and meta-analysis of randomized controlled trials. *Pharmacol Res* 2019;143:1–16.
112. Banach M, Katsiki N, Latkovskis G, et al. Postmarketing nutravigilance safety profile: a line of dietary food supplements containing red yeast rice for dyslipidemia. *Arch Med Sci* 2021. <https://doi.org/10.5114/aoms/133716>.
113. Lu Z, Kou W, Du B, et al. Effect of XuezhiKang, an extract from red yeast Chinese rice, on coronary events in a Chinese population with previous myocardial infarction. *Am J Cardiol* 2008;101(12):1689–1693.
114. Zhao SP, Liu L, Cheng YC, et al. XuezhiKang, an extract of cholestin, protects endothelial function through antiinflammatory and lipid-lowering mechanisms in patients with coronary heart disease. *Circulation* 2004;110(8):915–920.
115. Li JJ, Hu SS, Fang CH, et al. Effects of xuezhiKang, an extract of cholestin, on lipid profile and C-reactive protein: a short-term time course study in patients with stable angina. *Clin Chim Acta* 2005;352(1–2):217–224.
116. Hu J, Wang J, Gan QX, et al. Impact of red yeast rice on metabolic diseases: a review of possible mechanisms of action. *J Agric Food Chem* 2020;68(39):10441–10455.
117. Lin CP, Lin YL, Huang PH, Tsai HS, Chen YH. Inhibition of endothelial adhesion molecule expression by *Monascus purpureus*-fermented rice metabolites, monacolin K, ankaflavin, and monascin. *J Sci Food Agric* 2011;91(10):1751–1758.
118. Dong Y, Cheng H, Liu Y, Xue M, Liang H. Red yeast rice ameliorates high-fat diet-induced atherosclerosis in ApoE(–/–) mice in association with improved inflammation and altered gut microbiota composition. *Food Funct* 2019;10(7):3880–3889.
119. Zhu B, Qi F, Wu J, et al. Red yeast rice: a systematic review of the traditional uses, chemistry, pharmacology, and quality control of an important Chinese folk medicine. *Front Pharmacol* 2019;10:1449.

120. Lin CP, Huang PH, Tsai HS, et al. *Monascus purpureus*-fermented rice inhibits tumor necrosis factor- α -induced upregulation of matrix metalloproteinase 2 and 9 in human aortic smooth muscle cells. *J Pharm Pharmacol* 2011;63(12):1587–1594.
121. Penson PE, Banach M. Natural compounds as anti-atherogenic agents: clinical evidence for improved cardiovascular outcomes. *Atherosclerosis* 2021 Jan;316:58–65.
122. Banach M, Bruckert E, Descamps OS, et al. The role of red yeast rice (RYR) supplementation in plasma cholesterol control: a review and expert opinion. *Atheroscler Suppl* 2019 Dec;39:e1–e8.
123. Huang J, Liao LM, Weinstein SJ, Sinha R, Graubard BI, Albanes D. Association between plant and animal protein intake and overall and cause-specific mortality. *JAMA Intern Med* 2020;180(9):1173–1184.
124. Sirtori CR, Agradi E, Conti F, Mantero O, Gatti E. Soybean-protein diet in the treatment of type-II hyperlipoproteinaemia. *Lancet* 1977;1(8006):275–277.
125. Descovich GC, Ceredi C, Gaddi A, et al. Multicentre study of soybean protein diet for outpatient hyper-cholesterolaemic patients. *Lancet* 1980;2(8197):709–712.
126. Lovati MR, Manzoni C, Corsini A, Granata A, Fumagalli R, Sirtori CR. 7S globulin from soybean is metabolized in human cell cultures by a specific uptake and degradation system. *J Nutr* 1996;126(11):2831–2842.
127. Lovati MR, Manzoni C, Canavesi A, et al. Soybean protein diet increases low density lipoprotein receptor activity in mononuclear cells from hypercholesterolemic patients. *J Clin Invest* 1987;80(5):1498–1502.
128. Dewell A, Hollenbeck CB, Bruce B. The effects of soy-derived phytoestrogens on serum lipids and lipoproteins in moderately hypercholesterolemic postmenopausal women. *J Clin Endocrinol Metab* 2002;87(1):118–121.
129. Sirtori CR, Arnoldi A, Johnson SK. Phytoestrogens: end of a tale? *Ann Med* 2005;37(6):423–438.
130. Zhubi-Bakija F, Bajraktari G, Bytyci I, et al. The impact of type of dietary protein, animal versus vegetable, in modifying cardiometabolic risk factors: a position paper from the International Lipid Expert Panel (ILEP). *Clin Nutr* 2021;40(1):255–276.
131. Glazier MG, Bowman MA. A review of the evidence for the use of phytoestrogens as a replacement for traditional estrogen replacement therapy. *Arch Intern Med* 2001;161(9):1161–1172.
132. Azadbakht L, Kimiagar M, Mehrabi Y, Esmailzadeh A, Hu FB, Willett WC. Soy consumption, markers of inflammation, and endothelial function: a cross-over study in postmenopausal women with the metabolic syndrome. *Diabetes Care* 2007;30(4):967–973.
133. Zhu W, Ren L, Zhang L, Qiao Q, Farooq MZ, Xu Q. The potential of food protein-derived bioactive peptides against chronic intestinal inflammation. *Mediators Inflamm* 2020;2020:6817156.
134. Young D, Ibuki M, Nakamori T, Fan M, Mine Y. Soy-derived di- and tripeptides alleviate colon and ileum inflammation in pigs with dextran sodium sulfate-induced colitis. *J Nutr* 2012;142(2):363–368.
135. Khodarahmi M, Jafarabadi MA, Moludi J, Abbasalizad Farhangi M. A systematic review and meta-analysis of the effects of soy on serum hs-CRP. *Clin Nutr* 2019;38(3):996–1011.
136. Asbaghi O, Yaghubi E, Nazarian B, et al. The effects of soy supplementation on inflammatory biomarkers: a systematic review and meta-analysis of randomized controlled trials. *Cytokine* 2020;136:155282.
137. Charrier L, Merlin D. The oligopeptide transporter hPepT1: gateway to the innate immune response. *Lab Invest* 2006;86(6):538–546.
138. Walker SE, Adams MR, Franke AA, Register TC. Effects of dietary soy protein on iliac and carotid artery atherosclerosis and gene expression in male monkeys. *Atherosclerosis* 2008;196(1):106–113.
139. Sirtori CR, Lovati MR, Manzoni C, et al. Proteins of white lupin seed, a naturally isoflavone-poor legume, reduce cholesterolemia in rats and increase LDL receptor activity in HepG2 cells. *J Nutr* 2004;134(1):18–23.
140. Sirtori CR, Gianazza E, Manzoni C, Lovati MR, Murphy PA. Role of isoflavones in the cholesterol reduction by soy proteins in the clinic. *Am J Clin Nutr* 1997;65(1):166–167.
141. Sirtori CR, Triolo M, Bosio R, et al. Hypocholesterolaemic effects of lupin protein and pea protein/fibre combinations in moderately hypercholesterolaemic individuals. *Br J Nutr* 2012;107(8):1176–1183.
142. Lima-Cabello E, Alche JD, Morales-Santana S, Clemente A, Jimenez-Lopez JC. Narrow-leaved lupin (*Lupinus angustifolius* L.) seeds gamma-conglutin is an anti-inflammatory protein promoting insulin resistance improvement and oxidative stress amelioration in PANC-1 pancreatic cell-line. *Antioxidants (Basel)* 2019;9(1).
143. Magni C, Sessa F, Accardo E, et al. Conglutin gamma, a lupin seed protein, binds insulin in vitro and reduces plasma glucose levels of hyperglycemic rats. *J Nutr Biochem* 2004;15(11):646–650.
144. Boschin G, Scigliuolo GM, Resta D, Arnoldi A. ACE-inhibitory activity of enzymatic protein hydrolysates from lupin and other legumes. *Food Chem* 2014;145:34–40.
145. Boschin G, Scigliuolo GM, Resta D, Arnoldi A. Optimization of the enzymatic hydrolysis of lupin (*Lupinus*) proteins for producing ACE-inhibitory peptides. *J Agric Food Chem* 2014;62(8):1846–1851.
146. del Carmen Millán-Linares M, Bermúdez B, del Mar Yust M, Millán F, Pedraza J. Anti-inflammatory activity of lupine (*Lupinus angustifolius* L.) protein hydrolysates in THP-1-derived macrophages. *J Funct Foods* 2014;8:10.
147. Gao Y, Zhang X, Ren G, Wu C, Qin P, Yao Y. Peptides from extruded lupin (*Lupinus albus* L.) regulate inflammatory activity via the p38 MAPK signal transduction pathway in RAW 264.7 cells. *J Agric Food Chem* 2020;68(42):11702–11709.
148. Tong DC, Quinn S, Nasis A, et al. Colchicine in patients with acute coronary syndrome: the Australian COPS randomized clinical trial. *Circulation* 2020;142(20):1890–1900.
149. Reiner Ž, Sirtori CR, Banach M, Ruscica M, Sahebkar A. Methotrexate for cardiovascular risk reduction: the right choice? *Angiology* 2020;71(2):105–107.
150. Banach M, Penson P. Colchicine and cardiovascular outcomes: a critical appraisal of recent studies. *Curr Atheroscler Rep* 2021. <https://doi.org/10.1007/s11883-021-00932-5>.