High-dose resveratrol supplementation in obese men

An investigator-initiated, randomized, placebo-controlled clinical trial of substrate metabolism, insulin sensitivity, and body composition

Poulsen, Morten Møller; Vestergaard, Poul F.; Clasen, Berthil Frederik Forrest; Radko, Yulia; Christensen, Lars Porskjær; Stødkilde-Jørgensen, Hans; Møller, Niels; Jessen, Niels; Pedersen, Steen Bønløkke; Jørgensen, Jens Otto Lunde

Published in:
Diabetes

DOI:
10.2337/db12-0975

Publication date:
2013

Document version:
Final published version

Citation for published version (APA):

Go to publication entry in University of Southern Denmark's Research Portal

Terms of use
This work is brought to you by the University of Southern Denmark. Unless otherwise specified it has been shared according to the terms for self-archiving. If no other license is stated, these terms apply:
• You may download this work for personal use only.
• You may not further distribute the material or use it for any profit-making activity or commercial gain
• You may freely distribute the URL identifying this open access version

If you believe that this document breaches copyright please contact us providing details and we will investigate your claim. Please direct all enquiries to puresupport@bib.sdu.dk

Download date: 03. Apr. 2024
High-Dose Resveratrol Supplementation in Obese Men

An Investigator-Initiated, Randomized, Placebo-Controlled Clinical Trial of Substrate Metabolism, Insulin Sensitivity, and Body Composition

Morten M. Poulsen,1 Poul F. Vestergaard,1 Berthil F. Clasen,1 Yulia Radko,2 Lars P. Christensen,2 Hans Stødkilde-Jørgensen,3 Niels Møller,1 Niels Jessen,4 Steen B. Pedersen,1 and Jens Otto L. Jørgensen1

Obesity, diabetes, hypertension, and hyperlipidemia constitute risk factors for morbidity and premature mortality. Based on animal and in vitro studies, resveratrol reverses these risk factors via stimulation of silent mating type information regulation 2 homolog 1 (SIRT1), but data in human subjects are scarce. The objective of this study was to examine the metabolic effects of high-dose resveratrol in obese human subjects. In a randomized, placebo-controlled, double-blinded, and parallel-group design, 24 obese but otherwise healthy men were randomly assigned to 4 weeks of resveratrol or placebo treatment. Extensive metabolic examinations including assessment of glucose turnover and insulin sensitivity (hyperinsulinemic euglycemic clamp) were performed before and after the treatment. Insulin sensitivity, the primary outcome measure, deteriorated insignificantly in both groups. Endogenous glucose production and the turnover and oxidation rates of glucose remained unchanged. Resveratrol supplementation also had no effect on blood pressure; resting energy expenditure; oxidation rates of lipids; ectopic or visceral fat content; or inflammatory and metabolic biomarkers. The lack of effect disagrees with persuasive data obtained from rodent models and raises doubt about the justifiability of resveratrol as a human nutritional supplement in metabolic disorders. Diabetes 62:1186–1195, 2013

M anagement of obesity and its complications is a major health issue (1). Because primary preventive measures often fail and therapeutic options are insufficient, novel treatment modalities are being investigated (2). As such, the polyphenolic compound resveratrol has attracted attention over the past decades (3). It is widely distributed in nature and plays an important role in plants’ defenses against external stressors and infections; it also is a constituent of grapes and wine, albeit in minute amounts (on average, 1.9 mg/L in red wine) (4).

Preclinical trials suggest that resveratrol mimics the metabolic effects of calorie restriction (CR) (5) via activation of silent mating type information regulation 2 homolog 1 (SIRT1) (6–9). By means of NAD+-dependent deacetylase activity, SIRT1 modifies various target proteins, in particular transcription factors critical for energy metabolism, such as nuclear factor-κB, peroxisome proliferator-activated receptor γ coactivator 1-α, forkhead transcription factor class O, and sterol regulatory element-binding protein 1 (10,11).

In experimental animals, these effects translate into improved glucose metabolism (5,7,12–14), reduced inflammation (15–17), cancer prevention (18–21), reversal of nonalcoholic fatty liver disease (7,17,22–24), and prevention of obesity (8,25). In accordance with CR, supplementation with resveratrol promotes longevity in several primitive species (26–28) and protects against diet-induced metabolic abnormalities in rodents (7). Whether these effects of resveratrol apply to human beings remains uncertain, even though it is widely distributed as an over-the-counter nutritional supplement.

Only one trial systematically examining metabolic effects has been performed in humans: 11 obese male participants received a daily dose of 150 mg resveratrol or placebo for 30 days in a double-blind crossover design. Significant albeit moderate improvements in insulin sensitivity, blood pressure, metabolic rate, hepatic steatosis, and pertinent biomarkers were recorded (20). Apart from this single study, only a limited number of human clinical trials of efficacy outcomes have been conducted (30–32). In the present study we tested the impact of high-dose resveratrol administration for 4 weeks on energy and substrate metabolism, insulin sensitivity, ectopic fat disposition, 24-h ambulatory blood pressure, and inflammatory as well as metabolic biomarkers in obese human subjects.

RESEARCH DESIGN AND METHODS

Ethical approval. All participants were given oral and written information before written informed consent was obtained. The protocol was approved by the Regional Committee on Health Research Ethics and the Danish Data Protection Agency, and the study was conducted in accordance with the Declaration of Helsinki II. According to the International Committee of Medical Journal Editors, the protocol was registered at clinicaltrials.gov (NCT01150955) before recruitment was initiated.

Subjects. Twenty-four male volunteers, aged 18–70 years, participated. All participants were obese (BMI >30 kg/m²) but otherwise healthy, were taking no prescriptive medicine, and had no overt endocrine disorders. Eligibility

See accompanying commentary, p. 1022.
ultimately was based on a normal physical examination including routine clinical biochemistry and electrocardiography.

**Study design.** The study was an investigator-initiated randomized, double-blinded, placebo-controlled, parallel-group trial. The subjects were treated for 4 weeks with tablets containing 500 mg resveratrol (Fluxone Inc., Stenlose, Denmark) or placebo (Robinson Pharma, Santa Ana, CA) thrice daily. Randomization, blinding, packaging, and labeling was performed by the pharmacy at Aarhus University Hospital. The randomization code was unblinded once all predefined data were recorded.

During the trial period, the subjects were instructed to abstain from using nutritional supplements and co-consumption food suspected to contain resveratrol in significant amounts. Furthermore, the importance of maintaining their normal way of living was underscored. The compliance rate, defined as the proportion of tablets ingested relative to the intended number, was calculated when participants returned the remaining tablets during the last examination.

**Overall visits and interventions.** Examinations were performed on 3 consecutive days both at baseline and after 4 weeks of treatment with the same equipment and by the same physicians and laboratory technicians on both occasions.

On the first day we performed dual-energy X-ray absorptiometry scan and initiated 24-h ambulatory blood pressure recordings. On the second day, we conducted magnetic resonance (MR) spectroscopy and imaging, and on the third day and after an overnight fast the participants underwent a full-day metabolic investigation including a hyperinsulinemic euglycemic clamp with continuous infusion of a primed glucose tracer, indirect calorimetry, repetitive blood sampling, and muscle and adipose tissue biopsies.

When completing the full-day metabolic investigation at baseline, the tablets were provided and the subjects were instructed to initiate tablet consumption in the evening and subsequently three times daily until the overnight fast before the third examination day at week 4. At weeks 2, 4, and 6, potential adverse events were recorded, and fasting blood samples were drawn for safety purposes. Urine from the first void was collected for pharmacokinetic purposes in the morning of the third examination day at week 4.

**Hyperinsulinemic euglycemic clamp.** After an overnight fast (from 10:00 P.M.), the participants presented to the research unit at 7:30 A.M. and were studied in the supine position during thermoneutral conditions in the fasting state for 6 h.

For the purpose of infusions, a catheter (Venflon; Vigg, Helsingborg, Sweden) was inserted into an antecubital venous site and connected to a heated dorsal hand vein for sampling of arterialized blood. Samples were drawn at 0, 160, 170, 180, 340, 350, and 360 min; while the clamp was in place, plasma glucose levels were determined every 10 min.

The participants were studied from 8:00 A.M. to 2:00 P.M. (0–360 min) (Supplementary Fig. 1). After a 3-h basal period (0–180 min), they were clamped at a blood glucose level of 5–6 mmol/L with a 0.5 ml/kg/min insulin infusion (Actrapid; Novo Nordisk, Bagsværd, Denmark) for the last 3 h (180–360 min) by adjusting the infusion rate of 20% glucose (GIR) in response to blood glucose measurements every 10 min. After emptying the bladder at 0 min, urine was collected at the end of both the basal and clamp periods and the volume was measured.

**Muscle and adipose tissue biopsies.** Under sterile conditions and using local anesthesia, a 20-gauge needle (BD; 10 mg/ml Angros, Copenhagen, Denmark) skeletal muscle and adipose tissue biopsies were taken at the end of the basal period and 20 min into the clamp period (140 and 200 min, respectively). The muscle biopsy was obtained from the vastus lateralis muscle using a Bergström biopsy needle. The muscle tissue was immediately dissected free from fat and connective tissue and transferred to liquid nitrogen. Subcutaneous abdominal fat was obtained by liposuction 15 cm lateral to the umbilicus, cleaned, and subsequently snap-frozen in liquid nitrogen.

**[3-3H]-glucose tracer.** A primed continuous infusion of [3-3H]-glucose was given during the entire 6-h basal/clamp procedure (bolus 20 μCi followed by 0.19 μCi/min; NEN Life Science Products, Boston, MA). To avoid rapid dilution of [3-3H]-glucose during the hyperinsulinemic euglycemic clamp, [3-3H]-glucose was added to the infused glucose (100 μCi [3-3H]-glucose/500 ml 20% glucose) at a rate of 2 μCi/min.

Specific activity of [3-3H]-glucose was measured (33), and glucose rate of appearance (Ra) and rate of disappearance (Rd) was calculated at 10-min intervals from 150 to 180 and 330 to 360 min using Steele’s non-steady-state equation (34).

Under basal conditions, the endogenous glucose production (EGP) equals Rg, and during the clamp period, EGP is calculated by subtracting the mean GIR from Rg. Nonoxidative glucose disposal is derived by subtracting oxidative glucose disposal from total glucose disposal (Rd).

**Indirect calorimetry.** The respiratory quotient (RQ) and resting energy expenditure (REE) were estimated by indirect calorimetry (Deltatrac; Datex-Ohmeda, Helsinki, Finland) performed at 90–120 min and 270–300 min in the basal and clamp periods, respectively. Mean values taken during the last 25 min were used for calculations. Glucose and lipid oxidation rates were estimated after correction for protein oxidation, which was calculated on the basis of urea nitrogen excretion (35). Urea nitrogen content was measured by absorption photometry (ROCHE cobas 6000C, Roche Applied Science, Penzberg, Germany).

**Hormone analysis.** Plasma glucose was measured in duplicate immediately after sampling on an YSI 2300 Stat Plus (YSI Inc., Yellow Springs, OH). Glycated hemoglobin (HbA1c), alanine aminotransferase, and leukocytes were analyzed at the University Hospital Department of Clinical Biochemistry using standard methods. All other parameters were analyzed on serum that had been frozen and stored (−80°C) immediately after being drawn and centrifuged.

Total cholesterol, HDL, and triglycerides were determined by absorption photometry (ROCHE cobas 6000C, Roche Applied Science), and LDL subsequently was calculated using the Friedewald formula (36).

Insulin was analyzed using time-resolved immunofluorometric assay (AutoDELFIA Insulin kit, catalog no. B080–101, PerkinElmer, Turku, Finland) and free fatty acids (FFAs) by a commercially available kit (Wako Chemicals, Neuss, Germany). Glucagon and adrenocorticotropin were measured by in-house radioimmunoassay (37) and time-resolved immunofluorometric assay (38), respectively.

Finally, C-peptide (DakoCytomation, Cambridgeshire, UK), cortisol (Corisol ELISA, DRG Instruments GmbH, Marburg, Germany) and interleukin 6 (Human IL-6 Quantikine HS ELISA Kit [HB600B], R&D Systems, Minneapolis, MN); plasma tumor necrosis alpha human CCL2/MCP-1 Quantikine ELISA Kit (DCP00), R&D Systems); tumor necrosis factor alpha (Human TNF-α Quantikine HS ELISA [HSTA00D], R&D Systems); high-sensitivity C-reactive protein (CRP High Sensitive ELISA (EIA-3954), AH Diagnostics, Aarhus, Denmark) and leptin (Leptin ELISA E07, Medigast, Reutlingen, Germany) were analyzed using commercially available ELISA kits.

Hormones relevant to the clamp procedure (C-peptide, FFA, insulin, cortisol, adrenocorticotropin, glucagon) were measured at 0, 160, 170, 180, 340, 350, and 360 min and expressed as mean values of basal and clamp triplicates, respectively; the remainder were measured at 0 min. Homeostasis model assessment–insulin resistance (HOMA-IR) was calculated using the standard formula (39), based on fasting glucose and insulin.

**Magnetic resonance spectroscopy and imaging.** Intralipid and intramyocellular fat as well as visceral (VAT) and subcutaneous abdominal adipose tissue (SAAT) volumes were measured using magnetic resonance (MR) techniques using a Signa Excite 1.5 Tesla twin-speed scanner (GE Medical Systems, GE Healthcare, Little Chalfont, U.K.). MR spectroscopy of the skeletal muscle included a point-resolved spectroscopy sequence (water suppression; echo time 27 ms; repetition time 3000 ms) on a 2 × 2 × 2 cm voxel positioned in the largest cross-sectional area of the tibialis anterior muscle. Full width at half maximum was 13.4 ± 2.2 Hz. The 1H MR liver spectroscopy technique has been described previously (40); full width at half maximum was 13.7 ± 3.3 Hz. The spectra were quantified by using the LCModel software package (version 6.2; Stephen Provencher) by means of a dedicated muscle and liver spectroscopy fitting model. The data processing provided an estimate of the ratio of lipid to water in the tissue within the voxel (41). VAT and SAAT volumes were quantified by MR imaging (body coil; fast-spin echo sequence; echo time 8.5 ms; repetition time 600 ms; field thickness 8 mm; field of view 45 cm). On the basis of repetitive axial slices from the proximal border of the left kidney to the femur neck, data processing was done using the software package HippoFit (42).

**Dual-energy X-ray absorptiometry.** Whole-body bone mineral density and body composition were assessed by dual-energy X-ray absorptiometry (Hologic Discovery scanner SN 80027; Hologic Inc., Waltham, MA).

**Blood pressure.** Noninvasive, 24-h, ambulatory blood pressure monitoring was performed based on measurements every 20th minute (Spacelabs, model 90217).

**Western blotting.** Frozen muscles biopsies (−30 mg) were homogenized in ice-cold solubilization buffer (43), and samples were rotated for 60 min at 4°C. Insoluble materials were removed by centrifugation at 16,000g for 20 min at 4°C, and the protein content of the protein-containing supernatant was determined.

Aliquots of protein were resolved by SDS-PAGE, transferred to polyvinylidene fluoride membranes, and incubated with primary antibody. All primary antibodies were from Cell Signaling (Beverly, MA). To determine relative phosphorylation levels, phospho-specific blots were stripped in SDS buffer and reprobed with the primary antibody for the detection. Horseradish peroxidase (HRP)-tagged goat anti-rabbit immunoglobulin G (Amer sham, GE-Healthcare, Pittsburgh, PA) was used as the secondary antibody. Proteins were visualized by enhanced chemiluminescence (Pierce Supersignal West Dura; Thermo Scientific, Rockford, IL) using a ChemiDoc XRS+ CCD camera (BioRad, Hercules, CA).

**Real-time RT-PCR.** Total RNA was isolated from muscle and adipose tissue using Trizol (Gibco BRL, Life Technologies, Rockville, Denmark); RNA was quantified by measuring absorbance at 260 and 280 nm with a ratio >1.8 using
TABLE 1
Baseline characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Placebo</th>
<th>Resveratrol</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>31.9 ± 2.9</td>
<td>44.7 ± 3.5</td>
<td>0.01</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>115.9 ± 3.6</td>
<td>107.1 ± 2.7</td>
<td>0.065</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>35.9 ± 1.2</td>
<td>32.5 ± 0.6</td>
<td>0.053</td>
</tr>
<tr>
<td>Lean mass (kg)</td>
<td>73.4 ± 1.8</td>
<td>69.1 ± 1.6</td>
<td>0.083</td>
</tr>
<tr>
<td>Fat mass (kg)</td>
<td>37.0 ± 2.6</td>
<td>31.7 ± 1.4</td>
<td>0.078</td>
</tr>
<tr>
<td>Fat (%)</td>
<td>32.3 ± 1.4</td>
<td>30.2 ± 0.7</td>
<td>0.37</td>
</tr>
<tr>
<td>Visceral fat volume (cm³)</td>
<td>4285 ± 585</td>
<td>4996 ± 876</td>
<td>0.51</td>
</tr>
<tr>
<td>Abdominal subcutaneous fat volume (cm³)</td>
<td>10737 ± 1086</td>
<td>8103 ± 585</td>
<td>0.051</td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>126.1 ± 2.3</td>
<td>124.3 ± 2.9</td>
<td>0.64</td>
</tr>
<tr>
<td>Diastolic blood pressure (mmHg)</td>
<td>74.4 ± 1.6</td>
<td>75.6 ± 2.1</td>
<td>0.61</td>
</tr>
<tr>
<td>Glucose (mmol/L)</td>
<td>5.3 ± 0.1</td>
<td>5.6 ± 0.1</td>
<td>0.18</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>5.6 ± 0.1</td>
<td>5.6 ± 0.1</td>
<td>0.55</td>
</tr>
<tr>
<td>Total cholesterol (mmol/L)</td>
<td>5.3 ± 0.4</td>
<td>5.5 ± 0.3</td>
<td>0.65</td>
</tr>
<tr>
<td>HDL cholesterol (mmol/L)</td>
<td>0.9 ± 0.1</td>
<td>1.0 ± 0.1</td>
<td>0.84</td>
</tr>
<tr>
<td>LDL cholesterol (mmol/L)</td>
<td>3.2 ± 0.2</td>
<td>3.6 ± 0.2</td>
<td>0.22</td>
</tr>
<tr>
<td>Triglycerides (mmol/L)</td>
<td>2.0 ± 0.3</td>
<td>2.0 ± 0.3</td>
<td>0.97</td>
</tr>
</tbody>
</table>

Twenty-four volunteers were randomly assigned 4 weeks of placebo (n = 12) or resveratrol (n = 12) treatment. Values are shown as means ± SEM.

TABLE 2
Plasma biochemistry

<table>
<thead>
<tr>
<th>Glucose (mmol/L)</th>
<th>5.33 ± 0.08</th>
<th>5.33 ± 0.13</th>
<th>5.55 ± 0.14</th>
<th>5.55 ± 0.10</th>
<th>1.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin (pmol/L)</td>
<td>79.8 ± 10.4</td>
<td>79.9 ± 5.7</td>
<td>67.8 ± 7.8</td>
<td>71.0 ± 12.0</td>
<td>0.80</td>
</tr>
<tr>
<td>HOMA-IR index</td>
<td>3.17 ± 0.44</td>
<td>3.19 ± 0.27</td>
<td>2.78 ± 0.34</td>
<td>2.94 ± 0.52</td>
<td>0.82</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>5.56 ± 0.05</td>
<td>5.42 ± 0.05</td>
<td>5.61 ± 0.06</td>
<td>5.52 ± 0.05</td>
<td>0.33</td>
</tr>
<tr>
<td>Cholesterol (mmol/L)</td>
<td>5.27 ± 0.35</td>
<td>5.13 ± 0.21</td>
<td>5.47 ± 0.56</td>
<td>5.67 ± 0.24</td>
<td>0.27</td>
</tr>
<tr>
<td>HDL (mmol/L)</td>
<td>0.93 ± 0.06</td>
<td>1.02 ± 0.06</td>
<td>0.95 ± 0.07</td>
<td>0.94 ± 0.07</td>
<td>0.13</td>
</tr>
<tr>
<td>LDL (mmol/L)</td>
<td>3.19 ± 0.22</td>
<td>3.03 ± 0.17</td>
<td>3.59 ± 0.24</td>
<td>3.77 ± 0.23</td>
<td>0.22</td>
</tr>
<tr>
<td>Triglycerides (mmol/L)</td>
<td>2.03 ± 0.33</td>
<td>2.18 ± 0.29</td>
<td>2.04 ± 0.28</td>
<td>2.12 ± 0.28</td>
<td>0.80</td>
</tr>
<tr>
<td>Leptin (ng/mL)</td>
<td>19.47 ± 3.95</td>
<td>18.00 ± 1.98</td>
<td>18.80 ± 3.54</td>
<td>22.97 ± 6.65</td>
<td>0.32</td>
</tr>
<tr>
<td>hsCRP (ng/mL)</td>
<td>2.86 ± 0.39</td>
<td>4.04 ± 1.01</td>
<td>4.04 ± 0.73</td>
<td>4.58 ± 0.91</td>
<td>0.03</td>
</tr>
<tr>
<td>IL-6 (pg/mL)</td>
<td>3.21 ± 0.96</td>
<td>3.59 ± 0.72</td>
<td>4.84 ± 1.07</td>
<td>4.50 ± 0.77</td>
<td>0.60</td>
</tr>
<tr>
<td>TNF-α (pg/mL)</td>
<td>4.69 ± 0.79</td>
<td>5.00 ± 1.70</td>
<td>4.24 ± 0.84</td>
<td>4.14 ± 1.00</td>
<td>0.82</td>
</tr>
<tr>
<td>MCP-1 (pg/mL)</td>
<td>140.1 ± 7.5</td>
<td>134.2 ± 8.4</td>
<td>159.5 ± 10.7</td>
<td>178.4 ± 15.9</td>
<td>0.13</td>
</tr>
<tr>
<td>Leukocytes (10⁹/L)</td>
<td>5.98 ± 0.45</td>
<td>6.71 ± 0.58</td>
<td>6.23 ± 0.48</td>
<td>5.87 ± 0.35</td>
<td>0.04</td>
</tr>
<tr>
<td>ALT (U/L)</td>
<td>48.5 ± 5.4</td>
<td>54.6 ± 6.7</td>
<td>47.7 ± 10.2</td>
<td>46.9 ± 8.7</td>
<td>0.10</td>
</tr>
</tbody>
</table>

Circulating parameters before and after 4 weeks’ treatment with placebo (n = 12) or resveratrol (n = 12). All data are presented as means ± SEM. HOMA-IR, homeostasis model assessment–insulin resistance; hsCRP, high-sensitivity C-reactive protein; IL-6, interleukin 6; TNF, tumor necrosis factor; MCP-1, monocyte chemoattractant protein 1; ALT, alanine aminotransferase. *P values reflect overall comparison of the groups by two-way repeated-measures ANOVA.
TABLE 3
Substrate metabolism and circulating hormones

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>Resveratrol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
</tr>
<tr>
<td>Glucose oxidation (mg/kg/min)</td>
<td>1.09 ± 0.11</td>
<td>1.28 ± 0.13</td>
</tr>
<tr>
<td></td>
<td>1.15 ± 0.12</td>
<td>1.32 ± 0.09</td>
</tr>
<tr>
<td>Protein oxidation (mg/kg/min)</td>
<td>0.62 ± 0.08</td>
<td>0.50 ± 0.08</td>
</tr>
<tr>
<td></td>
<td>0.82 ± 0.09</td>
<td>0.64 ± 0.06*</td>
</tr>
<tr>
<td>Lipid oxidation (mg/kg/min)</td>
<td>0.58 ± 0.05</td>
<td>0.58 ± 0.06</td>
</tr>
<tr>
<td></td>
<td>0.44 ± 0.04*</td>
<td>0.48 ± 0.04*</td>
</tr>
<tr>
<td>Resting energy expenditure (kcal/24 h)</td>
<td>2143 ± 128</td>
<td>2170 ± 116</td>
</tr>
<tr>
<td></td>
<td>2125 ± 135</td>
<td>2144 ± 106</td>
</tr>
<tr>
<td>Respiratory quotient (%)</td>
<td>0.83 ± 0.01</td>
<td>0.84 ± 0.01</td>
</tr>
<tr>
<td></td>
<td>0.85 ± 0.01</td>
<td>0.85 ± 0.01</td>
</tr>
<tr>
<td>Insulin (pmol/L)</td>
<td>79.9 ± 10.4</td>
<td>79.8 ± 5.7</td>
</tr>
<tr>
<td></td>
<td>327.3 ± 16.2*</td>
<td>348.6 ± 18.2*</td>
</tr>
<tr>
<td>C-peptide (pmol/L)</td>
<td>1049 ± 68</td>
<td>1041 ± 43</td>
</tr>
<tr>
<td></td>
<td>790 ± 73*</td>
<td>895 ± 75*</td>
</tr>
<tr>
<td>Glucagon (pg/mL)</td>
<td>71.8 ± 10.9</td>
<td>74.4 ± 8.6</td>
</tr>
<tr>
<td></td>
<td>30.3 ± 3.2*</td>
<td>32.3 ± 3.9*</td>
</tr>
<tr>
<td>Cortisol (ng/mL)</td>
<td>80.2 ± 14.0</td>
<td>78.8 ± 12.3</td>
</tr>
<tr>
<td></td>
<td>65.8 ± 7.9</td>
<td>70.5 ± 6.6</td>
</tr>
<tr>
<td>Adiponectin (mg/L)</td>
<td>6.09 ± 0.65</td>
<td>6.65 ± 0.71</td>
</tr>
<tr>
<td></td>
<td>5.94 ± 0.64</td>
<td>6.45 ± 0.67*</td>
</tr>
<tr>
<td>FFA (mmol/L)</td>
<td>0.46 ± 0.04</td>
<td>0.43 ± 0.03</td>
</tr>
<tr>
<td></td>
<td>0.087 ± 0.011*</td>
<td>0.084 ± 0.014*</td>
</tr>
</tbody>
</table>

Major markers of substrate metabolism were assessed with (clamp period) and without (basal period) insulin stimulation before and after 4 weeks’ treatment with placebo (n = 12) or resveratrol (n = 12). The respiratory quotient and resting energy expenditure were estimated by indirect calorimetry. Glucose and lipid oxidation rates were calculated after correction for protein oxidation, which was estimated on the basis of urea nitrogen excretion. The presented circulating parameters were measured in triplicates at the end of the basal (160, 170, 180 min) and clamp (340, 350, 360 min) periods, respectively. The overall treatment effect was evaluated by two-way repeated-measures ANOVA or one-way ANOVA when relevant. All treatment comparisons were performed in the basal and clamp situations. No significant differences occurred due to the intervention. All data are presented as means ± SEM. *A statistically significant within-group effect (P < 0.05) of the insulin stimulation evaluated by a paired t test (i.e., basal vs. clamp).

RESULTS

Baseline and internal validity. A total of 26 subjects were enrolled, but one participant dropped out because of claustrophobia in relation to MR imaging, and another developed a generalized rash after 1 week and was excluded (Supplementary Fig. 2). Both placebo and resveratrol tablets were generally well tolerated (Supplementary Table 2). The compliance rates, based on pill count, were 89.2 ± 2.9% and 88.9 ± 3.3% in the placebo and resveratrol groups, respectively. By chance the two groups differed slightly in mean age but were comparable on all other baseline parameters (Table 1).

To document systemic absorption of the investigational product, we did a pharmacokinetic pilot study before the clinical trial. In that pilot study, three healthy subjects ingested one resveratrol tablet (from the same batch as the investigational product) of 500 mg followed by plasma samples at 0, 15, 30, 45, 60, 90, 120, 180, 240, and 300 min. The native compound reached traceable amounts at 15 min, and Cmax was reached at 90 min with 300–400 ng/mL, which is consistent with the literature (Supplementary Fig. 3) (44–48) yet distinctly below the concentration usually described in in vitro studies (50 μmol/L ≈ 11,400 ng/mL) (8). Furthermore, we compared the absorption profile of our investigational product (trans-resveratrol, Fluxome Inc., Stenlose, Denmark) with that of a similar product (500 mg resVida, DSM Nutritional Products, Ltd., Kaiseraugst, Switzerland). The two products exhibited similar absorption profiles (Supplementary Fig. 3).

The level of urinary resveratrol metabolites was determined at week 4, and no metabolites were detected in the placebo group, whereas measurable amounts were found in the resveratrol group (Supplementary Table 3).
Clinical biochemistry. We recorded no significant effects of resveratrol on HbA1c levels or the HOMA-IR. At baseline, the lipid profile was abnormal and compatible with obesity, but we observed no changes in total cholesterol, HDL, LDL, or triglycerides during the intervention period. Moreover, we did not record significant deviations in any inflammatory biomarkers, leptin, or liver function tests (Table 2).

Substrate metabolism. We did not record statistically significant changes in resting energy expenditure or respiratory quotient or in glucose or lipid oxidation rates when comparing basal and clamp values between the groups (Table 3). As expected, glucose oxidation increased during the clamp at the expense of reduced lipid oxidation. However, these changes did not differ either between or within the two groups (Table 3).

We also failed to detect significant differences in insulin, C-peptide, glucagon, cortisol, adiponectin, or FFAs between the groups. We recorded a significant within-group suppression of C-peptide, glucagon, and FFA levels during the clamp studies both before and after the intervention. We also found a statistically significant and expected decrease in insulin stimulated adiponectin. No within-group changes in cortisol levels were found during insulin stimulation (Table 3).

Insulin sensitivity. Insulin sensitivity assessed by the hyperinsulinemic euglycemic clamp method was not significantly affected by resveratrol. Insulin levels increased from ≈75 pmol/L in the basal period to ≈315 pmol/L in the clamp period, with no significant differences between the groups regarding the overall basal and clamp periods (P = 0.66 and P = 0.07, respectively). As depicted in Fig. 1A and B, the GIR increased during the clamp and plateaued...
toward the end of the clamp. GIR did not differ between the groups, and the corresponding M value, defined as the mean GIR during the last 30 min of the clamp, also was comparable between the groups (Fig. 1C). As expected, insulin increased the glucose uptake approximately threefold in the clamp situation compared with the basal condition in all experimental settings, with no significant differences between the two groups (Fig. 1D). Likewise, EGP during both the basal state and the clamp period was comparable between the two groups (Fig. 1E). Finally, the rates of oxidative as well as nonoxidative glucose disposal did not differ between the groups (Fig. 1F).

FIG. 3. Body composition. Absolute changes in essential body composition parameters after 4 weeks of placebo (n = 12) or resveratrol supplementation (n = 12). The box boundaries indicate the 25th–75th percentile range, and error bars represent the 5th–95th percentiles. Solid and dotted lines represent median and mean, respectively. A–D were assessed by whole-body dual-energy X-ray absorptiometry; E and F were quantified by MR imaging based on repetitive axial slices from the proximal border of the left kidney to the femur neck; nine were evaluable in each group. Two-way repeated-measures ANOVA revealed no statistically significant differences between groups.
Body composition. We did not demonstrate any significant differences in total body mass, lean body mass, total body fat mass, or visceral and abdominal subcutaneous fat volumes (Fig. 3).

Liver and skeletal muscle lipid content. Even though considerable hepatic fat infiltration was evident at baseline, no significant changes occurred in either group during the trial. The same was true when analyzing the intramyocellular lipid content (Fig. 4).

Gene expression and protein phosphorylation. Activation of AMP-activated protein kinase (AMPK) in the muscle tissue biopsies by phosphorylation of the Thr172 residue of the catalytic α-subunit was not impacted by resveratrol. Consistent with this, phosphorylation of acetyl-CoA carboxylase, a well-known downstream target of AMPK activity, also was not affected by the intervention. Furthermore, we explored the proposed SIRT1-mediated deacetylase activity potentially induced by resveratrol by assessing the total acetylation status of lysine residues, which also was not affected (Fig. 5 and Supplementary Fig. 4).

Apart from a slightly decreased insulin-stimulated expression of GLUT4 mRNA in muscle in the resveratrol group, gene transcription in muscle and fat did not change in any groups (Fig. 5 and Supplementary Fig. 4).

**DISCUSSION**

The main finding of our study is that short-term (4 weeks) supplementation with high-dose resveratrol is not associated with detectable physiological effects in obese subjects with modest insulin resistance. We consider this trial important for several reasons. First, the high incidence of obesity and type 2 diabetes calls for novel preventive and therapeutic modalities. Second, substantial evidence from preclinical work suggests that resveratrol stimulates SIRT1 activity and suppresses inflammatory pathways in human adipose tissue in vitro (49,50). Third, the compound is already widely available as an over-the-counter nutritional supplement with an array of alleged salutary effects. Fourth, resveratrol treatment may serve as a model to investigate potential biomarkers for CR and SIRT1 in human models.

Our primary outcome, insulin sensitivity, which was assessed by the hyperinsulinemic euglycemic clamp, was not significantly affected by resveratrol. The same was true for HOMA-IR, fasting glucose, and fasting insulin. Our negative findings are in conflict with the work by Timmers et al. (29), who demonstrated statistically significant improvements in HOMA-IR, suggesting a favorable effect on insulin sensitivity. However, the gold standard for the assessment of whole-body insulin sensitivity is the hyperinsulinemic euglycemic clamp technique used in our study. Furthermore, our inclusion of glucose tracer allowed for the determination of glucose turnover in the basal state and EGP during the clamp, all of which also failed to be affected by resveratrol. We also found no effects of resveratrol on either resting energy expenditure or rates of lipid oxidation.

When assessing blood pressure, we found a trend toward a moderate increase in 24 h blood pressure after resveratrol administration compared with placebo. Again, the differences were insignificant and in opposition to the findings by Timmers et al. (29), who recorded a robust decrease in both systolic and diastolic blood pressures, which were assessed by the mean of conventional clinical blood pressure triplicates. Furthermore, we examined the ectopic fat content in hepatic and muscle tissue by MR spectroscopy and, in contrast to Timmers et al., we recorded no effects of resveratrol. In preclinical settings, the finding of diminished hepatic fat induced by resveratrol is consistent, and the reason why we fail to reproduce the findings by Timmers et al. could relate to baseline differences. Because lipid content is expressed as a relative number relative to the water content, we cannot directly compare the data sets. In accordance with the ectopic fat content, we also failed to detect changes in adipose tissue assessed by MR imaging, which perhaps is less surprising considering the relatively short duration of treatment.

Consistent with the lack of physiological responses to high-dose resveratrol, we also did not find any alterations in gene expression of a panel of pivotal metabolic and

**FIG. 4. Ectopic lipid. Relative changes in ectopic lipid deposition from baseline after 4 weeks of placebo or resveratrol supplementation, respectively. Results are generated by 1H-MR spectroscopy and raw data processing provide an estimate of the ratio of lipid to water (LWR) within the tissue. The box boundaries indicate the 25th–75th percentile range, and error bars represent the 5th–95th percentiles. Solid and dotted lines represent median and mean, respectively. Two-way repeated-measures ANOVA revealed no statistically significant differences between groups. A: Changes in hepatic lipid content; 11 were evaluable in each group. B: Changes in intramyocellular lipid (IMCL) content; 10 were evaluable in each group.**

**Blood pressure.** We recorded continuous ambulatory blood pressure profiles over 24 h, which were not affected by resveratrol (Fig. 2). The tendency of resveratrol to increase mean systolic (delta change 2.75 ± 1.38 mmHg) as well as mean diastolic (delta change 2.25 ± 0.58 mmHg) blood pressures was nonsignificant when compared with the placebo group (systolic, P = 0.39; diastolic, P = 0.36).

**Liver and skeletal muscle lipid content.** Even though considerable hepatic fat infiltration was evident at baseline, no significant changes occurred in either group during the trial. The same was true when analyzing the intramyocellular lipid content (Fig. 4).

**Gene expression and protein phosphorylation.** Activation of AMP-activated protein kinase (AMPK) in the muscle tissue biopsies by phosphorylation of the Thr172 residue of the catalytic α-subunit was not impacted by resveratrol. Consistent with this, phosphorylation of acetyl-CoA carboxylase, a well-known downstream target of
FIG. 5. Gene expression and protein phosphorylation. Intracellular protein levels and relative mRNA expression in muscle (A–D) and adipose (E and F) tissue biopsies taken before and after 4 weeks’ treatment with placebo (n = 12) or resveratrol (n = 12). Biopsies were taken before and during (20 min after initiation) a hyperinsulinemic euglycemic clamp. Black bars indicate the placebo group and white bars indicate the resveratrol group. Results are presented as group means ± SEM, and overall comparisons of potential treatment effects were performed by two-way repeated-measures ANOVA in the basal and clamp situations, respectively. A: Phosphorylation of the intracellular kinase AMP-activated protein kinase (AMPK) assessed by Western blot analysis in muscle tissue. B: Total acetylation of lysine residues assessed by Western blot analysis in muscle tissue. C: Relative GLUT4 mRNA expression in muscle tissue assessed by RT-PCR. D: Relative peroxisome proliferator-activated receptor γ coactivator 1-α (PGC1α) mRNA expression in muscle tissue assessed by RT-PCR. E: Relative tumor necrosis factor (TNF)-α mRNA expression in subcutaneous adipose tissue assessed by RT-PCR. F: Relative nuclear factor (NF)-κB mRNA expression in subcutaneous adipose tissue assessed by RT-PCR. *In C, we found an overall treatment effect in the clamp situation, and a post hoc test revealed a statistically significant (P < 0.05) decreased expression of GLUT4 in the resveratrol group.
inflammatory biomarkers. Nor were protein phosphorylation levels of AMPK and acetyl-CoA carboxylase or total acetylation status affected. As mentioned, our data disagree with the recently published work by Timmers et al. (29), who recorded significant effects using only one-tenth of our dose in a group of obese men. In comparison with the participants in the study by Timmers et al., ours were slightly younger (age 38.4 ± 2.6 vs. 52.5 ± 2.1 years) and more obese (BMI 34.2 ± 0.7 vs. 31.59 ± 0.7 kg/m²; fat 31.3 ± 0.8 vs. 26.4 ± 0.5%). To what degree age and extent of obesity may impact the effect of resveratrol in human subjects remains to be investigated. We have scrutinized our design to identify potential design-related problems to explain the lack of effect. We have demonstrated that the absorption of our resveratrol formulation is comparable to the absorption of the compound used in the study by Timmers et al. Our study groups were well matched and of a reasonable sample size, the compliance was good, and we consider the duration of treatment sufficient. The difference in age between our two treatment groups was due to two outliers in the resveratrol group, aged 60 and 68 years. We have repeated all our analysis without these two outliers, which did not change the negative outcome (data not shown). Finally, the risk of a type 2 error due to low sample size should also be considered. In the study by Timmers et al., a sample size of 11 was sufficient to demonstrate effects in a cross-over design. Compared with that study, ours holds the potential advantage of a parallel design, which eliminates the risk of untoward seasonal changes and carry-over effects. A limitation of our study is the inability to directly demonstrate the presence of resveratrol and metabolites in plasma. However, we demonstrated the absorption and excretion of the investigational product by means of our pharmacokinetic pilot study and urinary metabolite measurements.

Based on solid preclinical evidence, it is likely that a certain degree of baseline metabolic abnormalities is a prerequisite to benefit from resveratrol treatment, and it could be speculated that our participants were “too healthy.” However, both HOMA and M values at baseline may indicate mild insulin resistance in our cohort: a HOMA value of 2.77 previously has been defined as the threshold for insulin resistance in metabolically healthy subjects (51). Moreover, in a group of lean but slightly younger men (BMI, 24.6 ± 3.2 kg/m²; age 23.0 ± 2.0 years) clamped at an identical insulin dose and with the same procedures as those used in our laboratory, we recorded an M value of 5.8 mg/kg/min after 3 h (52) compared with 2.5 mg/kg/min in the current study, which suggests a 60% reduction in insulin sensitivity in our participants. Nonetheless, in future studies, and before making any definitive conclusions, the therapeutic potential of resveratrol should be tested in patients with more pronounced morbidity such as type 2 diabetes, nonalcoholic fatty liver disease, and hypertension.

Little is known about the pharmacodynamic properties of resveratrol. Even though the preclinical evidence is quite substantial, basic mechanisms of action are not elucidated or agreed upon. SIRT1 seems to be a pivotal mediator of the metabolic effects of resveratrol, but the up- and downstream mechanisms are not fully understood. One of the main questions pending is whether the effects depend on AMPK and, if so, whether AMPK activation is up- or downstream of SIRT1. Regardless of our inability to demonstrate AMPK activation, resveratrol may have potential targets in addition to AMPK and SIRT1. Emerging evidence suggests certain pathways are affected differently at different dose levels, with subsequent effects on physiological outcomes, both in vitro (53) and in vivo (22). In fact, to our knowledge, the latter work is the first to report an inverse dose-response relationship in vivo; more pronounced effects apparently are observed at lower doses. Even though an inverted or J-shaped dose-response relationship seems to be an unlikely explanation for our results, this remains a possibility. Future studies should focus on dose-response relationships and preferably also compare the impact of treatment duration, including potential acute effects of resveratrol. It also remains to be reported whether alternative small-molecule activators of SIRT1 (STACs) may be more effective compared with resveratrol in clinical settings. Regardless of our findings, the scientific field of sirtuin biology remains an area of great interest.

ACKNOWLEDGMENTS

This work was supported by grants from the Danish Agency for Science Technology and Innovation (Grant 09-072323), The Novo Nordisk Foundation, Karen Elise Jensens Foundation, The Toyota Foundation, Elvira and Rasmus Riisfort Foundation, Ejnar Danielsens Foundation, and the AP Møller Maersk Foundation. The study is also part of the research program at LIRMOI Research Center (www.LIRMOI.com), which is supported by the Danish Council for Strategic Research (Grant 10-093499). No other potential conflicts of interest relevant to this article were reported.

M.M.P., N.M., N.J., S.B.P., and J.O.L.J. conceived of and designed the study. P.F.V. and H.S.J. performed MR scans and processed the raw MR data. B.F.C. performed Western blotting analyses. Y.R. and L.P.C. performed plasma and urine pharmacokinetic analyses. M.M.P. performed all other investigations and analyses and further analyzed data. M.M.P. and J.O.L.J. wrote the manuscript, which was reviewed by all authors. M.M.P. is the guarantor of this work and, as such, had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

The authors thank medical laboratory technicians Pia Hornbek, Karen Mathiassens, Annette Mengel, Inge Merete Møller, Lenette Pedersen, Hanne Fjeldset Petersen, Eva Schriver, and Dorte Emilie Wulff, from the Medical Research Unit, Aarhus University Hospital, for their excellent technical assistance. The authors also thank Fluxome for providing the resveratrol and placebo tablets.

REFERENCES


