Nutritional advantages of probiotics and prebiotics

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The potential ‘nutritional advantages’ of probiotics and prebiotics consist of preventive, and sometimes curative, effects against certain diseases. The evidence supporting such advantages, which requires randomised controlled trials and consistency of results from study to study, is rapidly increasing. This article summarizes the effects against diseases of intestinal origin. There is a high level of evidence for positive effects of some prebiotics to alleviate constipation and treat hepatic encephalopathy. Interesting aspects, but with a lower level of evidence at the present time, include prevention of colon cancer, intestinal infection, and recurrence of inflammatory bowel disease. There is a high level of evidence for positive effects of some probiotics in the alleviation of lactose intolerance, antibiotic-associated intestinal disorders and gastrointestinal. Evidence is rapidly growing regarding the prevention of recurrence of inflammatory bowel diseases. Positive trials have suggested preventive effects against intestinal colonization with specific gut pathogens including Clostridium difficile and Helicobacter pylori.

Probiotics: Prebiotics: Disease prevention by food

Introduction

Probiotics have been defined as viable microbial food supplements which beneficially influence the health of the host (Schrezenmeir & De Vrese, 2001). Prebiotics are food ingredients that are largely undegraded in the small bowel and can beneficially affect the host by selectively stimulating the growth and/or activity of one or a limited number of bacteria (Schrezenmeir & De Vrese, 2001). In farm animals, probiotics and prebiotics may enhance growth and prevent early mortality, especially from infections (Huber, 1997; Mulder et al. 1997). In humans, their potential ‘nutritional advantages’ consist of preventative curative effects against diseases including intestinal dysfunctions, gastro-intestinal infections, inflammatory bowel disease and possibly colon cancer. The evidence supporting nutritional advantages of probiotics and prebiotics is rapidly increasing. Many studies now follow a pharmacological approach, and the rules of evidence-based medicine. The demonstration of a high or reasonable level of evidence requires randomized-controlled trials (RCT), and consistency of results from study to study. The effects of probiotics and prebiotics on mineral absorption, lipid metabolism, and cancer risk are discussed in other articles in the same issue of this journal, and the present article summarizes the effects against intestinal diseases (or diseases of intestinal origin).

Do the nutritional advantages of prebiotics and probiotics differ?

Although prebiotics and probiotics probably share common mechanisms of action (especially modulation of the endogenous flora), they differ in their composition and metabolism. The fate of prebiotics in the gastrointestinal tract is better known than that of probiotics. Prebiotics, like other low digestible carbohydrates, exert an osmotic effect in the gastrointestinal tract as long as they are not fermented; when they are fermented by the endogenous flora, i.e. at the place where they exhibit their prebiotic effect, they also increase intestinal gas production (Roberfroid & Slavin, 2000). Prebiotics have therefore the theoretical risk to increase diarrhoea in some situations (because of the osmotic effect) and to be poorly tolerated in patients with irritable bowel syndrome. The tolerance of low doses of prebiotics is nevertheless usually excellent (Marteau & Flourié, 2001). Probiotics do not have this theoretical drawback, and have often been effective to prevent or alleviate various clinical situations with diarrhoea.

Note: For the definition of the terms inulin and oligofructose please refer to the introductory paper (p. S139) and its footnote.

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**Prebiotics**

**Demonstrated effects**

*Alleviation of constipation.* Low digestible carbohydrates with a low molecular weight exhibit a positive effect on intestinal transit in constipated patients. This is probably due not only to their osmotic effect but also to other mechanisms, which may include modulation of the indigenous microflora (Clausen & Mortensen, 1997).

*Treatment of hepatic encephalopathy.* Several RCT have shown that lactulose and lactitol are superior to placebo to treat hepatic encephalopathy (Clausen & Mortensen, 1997; Dhiman et al. 2000). The mechanisms involved include: bacterial incorporation of nitrogen and acidification of the colonic environment which in turn reduces the breakdown of nitrogen-containing compounds to ammonia and other potential cerebral toxins (Weber, 1996).

**Other potential applications (lower level of evidence at the present time)**

Pre-clinical studies have suggested that prebiotics may have promising properties in inflammatory bowel disease (Szilagyi, 1998), prevention of cholesterol gallstones (Rotstein et al. 1981), and prevention of infections of intestinal origin (Dai & Walker, 1999). Well controlled studies in patients are needed.

Protective effects against colon cancer have also been suggested. There is some experimental evidence that secondary bile salts are involved in colonic carcinogenesis, and that non digestible oligosaccharides can decrease the faecal concentration, probably through colonic pH reduction. Several animal studies have supported the hypothesis and even suggested that other mechanisms could be involved (Pool-Zobel et al. 2002). Roncucci et al. (1993) reported that lactulose decreased the recurrence rate of colon adenomas. Two hundred and fifty-five patients with colon adenomas were randomized after removal of the adenomas to receive vitamins, lactulose (20 g/d) or no treatment. Colonoscopy was performed thereafter every 6 months. After a mean follow-up of 18 months, the percentages of recurrence of adenomas were 5-7% in the vitamin group, 14-7% in the lactulose group, and 35-9% in the untreated patients. Unfortunately, this study was not blinded and has not yet been confirmed.

**Probiotics**

**Demonstrated effects**

*Improvement of lactose intolerance and other enzymatic effects.* Lactose maldigestion is a frequent situation for many adults. Studies have demonstrated that digestion and tolerance are improved when lactose is ingested in yogurt containing live bacteria than when it is consumed in milk or heated yogurt (in which the bacteria have been killed during the heating process) (de Vrese et al. 2001). This effect is largely due to digestion of lactose in the gut lumen by lactase contained in yogurt bacteria and released in the small bowel when these bacteria are lysed by bile acids (Marteau et al. 1990). In clinical practice, replacement of milk by yogurt or fermented dairy products decreases or suppresses the symptoms of lactose intolerance (de Vrese et al. 2001).

Preliminary trials have suggested that sucrase or lipase could be delivered in the small bowel in subjects or animals with enzyme deficiency using natural or genetically modified probiotic vectors (Harms et al. 1987; Drouault et al. 2001). However, this way of delivery needs to be studied in more robust detail.

*Antibiotic associated diarrhoea.* Diarrhoea occurs in up to 20% of patients who receive antibiotics, and results from microbial imbalance. Several randomized double-blind trials have demonstrated that Saccharomyces boulardii, Lactobacillus rhamnosus GG, and Enterococcus faecium SF68 are significantly more efficient than a placebo to decrease the risk of diarrhoea in healthy volunteers or patients receiving antibiotics (Marteau et al. 2001a; Szajewska et al. 2001; Armuzzi et al. 2001). The mechanism involved is unclear, and is in fact probably not unique. For example, oral administration of S. boulardii has been shown in humans or animals treated with antibiotics to decrease, in some cases, the colonization of the endogenous ecosystem by C. difficile, in other cases to decrease the toxin production by C. difficile, and in other experiments to protect the epithelial barrier function (Elmer et al. 1996; Czerucka et al. 2000). Other probiotic products may work as well but they have not (hitherto) been sufficiently well studied to reach a fair level of evidence.

**Gastroenteritis.** Gastroenteritis is a frequent disorder that heals, usually spontaneously, within a few days. Several RCT demonstrated a beneficial effect of L. rhamnosus GG in the treatment of infant diarrhoea, especially due to rotavirus infection (Guandalini et al. 2000; Marteau et al. 2001a). It was suggested in one study that heat inactivated L. rhamnosus was as effective as living L. rhamnosus on diarrhoea, however the effect of the living probiotic was more pronounced on rotavirus specific IgA response (Kaila et al. 1995). E. faecium SF 68 (Bioflorin®, Giuliani, Switzerland) has also been shown to significantly shorten diarrhoea in four RCT. Other probiotics are probably also effective (Marteau et al. 2001a).

Saavedra et al. (1994) showed that the preventive feeding of Bifidobacterium bifidum and S. thermophilus to infants, admitted to hospital, significantly reduced the risk of diarrhoea and shedding of rotavirus. In a double-blind placebo controlled trial, fifty-five children admitted to a chronic medical care unit were randomized to receive a standard formula or the same plus Bifidobacterium bifidum and S. thermophilus. During follow up, diarrhoea occurred in 7% of the children receiving the probiotic versus 31% of the controls. The shedding of rotavirus was also reduced to 10% versus 39%.

**Other potential applications (lower level of evidence at the present time)**

*Inflammatory bowel disease (IBD).* Inflammatory bowel diseases (IBD) are disorders of unknown cause characterized by chronic or recurrent intestinal inflammation. They include ulcerative colitis, Crohn’s disease,
and pouchitis. The mechanisms responsible for initiation and perpetuation of the inflammatory process remains unknown but the main theory is that IBD may result from abnormal host responses to some members of the intestinal flora, and/or from a defective mucosal barrier (Shanahan, 2001). Several RCT have recently demonstrated that certain probiotics could be of great clinical interest and need to be further studied (Table 1). For some, the level of evidence is close to that needed for physicians to prescribe them to patients. Trials are ongoing and knowledge is progressing quickly in this field (for a review see Marteau & Shanahan, in press).

**Intestinal infections and colonisation by pathogenic bacteria.** Protective effects of probiotics against intestinal infections have been demonstrated in animal models and seem to be an important mechanism for ‘nutritional advantages’, i.e. growth stimulation and decrease in mortality (Huber, 1997; Mulder et al. 1998). A significant reduction of the urease activity has been reported (Coconnier et al. 1998). A significant reduction of the urease activity has been reported in patients treated with a supernatant of *L. johnsonii* LA1 (Nestlé, Switzerland) associated with omeprazole (Michetti et al. 1999). Two RCT have recently reported that the ingestion of a fermented dairy product containing this strain or a heat killed *Lactobacillus acidophilus* could help to decrease the gastric colonization by *H. pylori* (Canducci et al. 2000; Felley et al. 2001). Further confirmation and proof of effect is needed. 

**Traveller’s diarrhoea.** Acute diarrhoea occurs in about half of travellers to high risk-areas. Several RCT were performed using probiotics (see references in Marteau et al. 2001a), however, their methodology was often insufficient (e.g. drop outs, statistics, end-points) such that no clear conclusion could be drawn.

**Irritable bowel syndrome (IBS).** Several authors have tested the effects of various probiotics in subjects with IBS. At the present time, the level of proof is low and the majority of trials were negative. It seems however, an interesting track as at least two RCT have shown that some probiotics could influence the transit time of healthy humans (Bouglé et al. 1999; Marteau et al. 2001b).

**Colon cancer.** Regular consumption of some probiotics may decrease the faecal levels of enzymes, mutagens, and secondary bile salts which may be involved in colonic carcinogenesis (Wollowski et al. 2001). Some, but not all, epidemiological studies have also suggested that consumption of fermented dairy products may have some protective effect against large colon adenomas or cancer (Boutron et al. 1996). Clinical studies are currently ongoing in Europe to study the effects of probiotics in subjects with colon adenomas.

### Table 1. Results of randomized controlled trials which reported efficacy of probiotics in patients with inflammatory bowel disease

<table>
<thead>
<tr>
<th>Situation (prevention)</th>
<th>Probiotic</th>
<th>Control</th>
<th>n</th>
<th>Duration</th>
<th>Relapse: probiotic group/control</th>
<th>P</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcerative colitis</td>
<td><em>E. coli Nissle</em> 1917</td>
<td>5-ASA</td>
<td>120</td>
<td>4 months</td>
<td>16% / 11.3%</td>
<td>NS</td>
<td>Kruis et al. (1997)</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td><em>E. coli Nissle</em> 1917</td>
<td>5-ASA</td>
<td>120</td>
<td>12 months</td>
<td>67% / 73%</td>
<td>NS</td>
<td>Rembacken et al. (1999)</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td><em>S. boulardii</em> + 5-ASA</td>
<td>5-ASA</td>
<td>31</td>
<td>12 months</td>
<td>30% / 35%</td>
<td>NS</td>
<td>Copaci et al. (2000)</td>
</tr>
<tr>
<td>Pouchitis (chronic)</td>
<td>VSL #3</td>
<td>placebo</td>
<td>40</td>
<td>9 months</td>
<td>15% / 100%</td>
<td>&lt;0.05</td>
<td>Gionchetti et al. (2000a)</td>
</tr>
<tr>
<td>Pouchitis</td>
<td>VSL #3</td>
<td>placebo</td>
<td>40</td>
<td>12 months</td>
<td>10% / 40%</td>
<td>&lt;0.05</td>
<td>Gionchetti et al. (2000b)</td>
</tr>
<tr>
<td>Crohn’s disease (post-operative recurrence)</td>
<td>VSL #3</td>
<td>5-ASA</td>
<td>28</td>
<td>12 months</td>
<td>20% / 40%</td>
<td>&lt;0.05</td>
<td>Campieri et al. (2000)</td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td><em>E. coli Nissle</em> 1917</td>
<td>placebo</td>
<td>28</td>
<td>12 months</td>
<td>30% / 70%</td>
<td>&lt;0.05</td>
<td>Malchow (1997)</td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td><em>S. boulardii</em> + 5-ASA</td>
<td>5-ASA alone</td>
<td>28</td>
<td>6 months</td>
<td>6.3% / 37.5%</td>
<td>&lt;0.05</td>
<td>Guslandi et al. (2000)</td>
</tr>
</tbody>
</table>

VSL#3 (CSL, Milan, Italy) contains 300 billion viable lyophilized bacteria per gram of four strains of lactobacilli (*L. casei*, *L. plantarum*, *L. acidophilus*, *L. delbrueckii* subsp. *bulgaricus*), three strains of bifidobacteria (*B. longum*, *B. breve*, *B. infantis*), and one strain of *Streptococcus salivarius* subsp. *thermophilus*.

5-ASA: 5-aminosalicylic acid.

and *Helicobacter pylori in vitro* have been reported (Coconnier et al. 1998). *Helicobacter pylori* inactivation has now clearly been demonstrated in specific fields with *Helicobacter pylori in vivo* (e.g. drop outs, statistics, end-points) such that no clear conclusion could be drawn.
References


