Effects of carotenoids on human immune function

David A. Hughes

Diet, Health and Consumer Science Division, Institute of Food Research, Norwich Research Park, Norwich NR4 7UA, UK

Many epidemiological studies have shown an association between diets rich in carotenoids and a reduced incidence of many forms of cancer, and it has been suggested that the antioxidant properties of these compounds are a causative factor. Attention has focused on the potential role of one specific carotenoid, β-carotene, in preventing cancer, and numerous publications have described in vitro experiments and animal studies which suggest that not only can this carotenoid protect against the development of cancer, but also several other chronic diseases. Since the immune system plays a major role in cancer prevention, it has been suggested that β-carotene may enhance immune cell function. Several human trials, using dietary β-carotene supplementation with a wide range of intakes, have been undertaken to address this hypothesis. The general conclusion of these studies is that this compound can enhance cell-mediated immune responses, particularly in the elderly. The present article will review some of these human studies and, hopefully, complement the reviews of other authors associated with the present symposium, some of whom will also describe work in this area. Potential mechanisms for the effects of carotenoids on immune function will also be reviewed. Finally, possible reasons for the failure of three major prospective studies to demonstrate a beneficial effect of β-carotene supplementation on lung cancer risk will be discussed.

Carotenoids: Immune function: β-Carotene: Monocyte

The carotenoids are a group of over 600 naturally-occurring coloured pigments that are widespread in plants, but of which only about twenty-four commonly occur in human foodstuffs. In nature they serve two essential functions: as accessory pigments in photosynthesis, and in photoprotection. These two functions are achieved through the polyene structure of carotenoids (Fig. 1), which allows the molecules to absorb light and to quench singlet oxygen and free radicals.

The human body is under constant assault from reactive oxygen species, formed as a natural consequence of the body’s normal metabolic activity and as part of the immune system’s strategy for destroying invading micro-organisms. In addition, the body is exposed to several exogenous sources of free radicals, including ozone, u.v. radiation in sunlight, and cigarette smoke. These unstable molecules can harm the body in many ways, by damaging DNA, denaturing proteins and by causing cell-membrane-lipid peroxidation. Fortunately, the body has developed many defences against this damage, and these defences include both mineral-dependent enzymes (such as Se-dependent

Abbreviations: DTH, delayed-type hypersensitivity; HIV, human immunodeficiency virus; HLA, human leucocyte-associated antigen; ICAM-1, intercellular adhesion molecule-1; IL, interleukin; MHC, major histocompatibility complex; NK, natural killer

Corresponding author: Dr D. A. Hughes, fax +44 (0) 1603 255237, email davida.hughes@bbsrc.ac.uk
inflammatory cytokines that increase local blood capillary wall permeability. This results in the influx of fluid and protein into the tissue, producing a characteristic red weal and skin swelling. The lack of a DTH response, particularly in the elderly, is associated with an increased risk of morbidity and mortality (Wayne et al. 1990).

Individuals who are repeatedly exposed to u.v. light show suppression of immune function (Rivers et al. 1989). Since carotenoids can provide photoprotection, several studies have assessed the ability of β-carotene to protect the immune system from u.v.-induced free radical damage. In one study a group of young males were placed on a low-carotenoid diet (<1.0 mg total carotenoids/d) and given either placebo or 30 mg β-carotene/d for 28 d before periodic exposure to u.v. light. DTH responses were significantly (P < 0.05) suppressed in the placebo group after u.v. treatments, and the suppression was inversely proportional to plasma β-carotene concentrations in this group (Fuller et al. 1992). No significant suppression of DTH responses were seen in the β-carotene-treated group. Similar results have also been reported in a more recent study of healthy elderly subjects (Bendich, 1996) who were also supplemented with 30 mg β-carotene/d or a placebo. However, in this study, although all participants were placed on a low-carotenoid diet, each was supplemented with an additional 1·5 mg β-carotene/d (the USA average daily intake). Interestingly, the decline in DTH responses in the placebo-treated group was not as significant as that seen in the previous study, suggesting that an intake of 1·5 mg β-carotene/d may still provide some protection. The ability of β-carotene to protect against the harmful effects of natural u.v.-sunlight has also been demonstrated (Gollnick et al. 1996) by exposing healthy female students to time- and intensity-controlled sunlight exposure (a Berlin-based study which involved taking volunteers to the Red Sea!).

**β-Carotene and lymphocyte function**

Several studies have examined the effects of β-carotene on immune function by measuring changes in the numbers of lymphocyte subpopulations and on the expression of cell activation markers. Various doses of β-carotene have been employed in these studies, ranging from dietary achievable levels of 15 mg/d up to pharmacological doses of 180 mg/d, provided over periods of 14–365 d.

There have been reported increases in the numbers of T-helper lymphocytes (CD4+) or in CD4+CD8+ (T-suppressor/cytotoxic cells) T-cells, and in the percentages of lymphocytes expressing the activation markers, interleukin (IL) 2 receptor and transferrin receptor (Alexander et al. 1985; Watson et al. 1991; Murata et al. 1994), particularly in elderly subjects. The potential for increasing the numbers of CD4+ cells led to the suggestion that β-carotene might be useful as an immunoenhancing agent in the treatment of human immunodeficiency virus (HIV) infection. Preliminary studies have shown a slight but non-significant increase in CD4+ numbers in response to β-carotene (60 mg/d for 4 weeks) in patients with acquired immune deficiency syndrome (Fryburg et al. 1995), but long-term effectiveness has not been reported. However, a recent study of forty-nine HIV-infected subjects, provided...
with vitamin E and vitamin C, observed a significant ($P < 0.01$) reduction in oxidative stress and a trend towards a reduction in viral load after 3 months (Allard et al. 1998). This study suggests that larger trials of these and other antioxidant nutrients in the treatment of HIV-infected persons are worthwhile, since there is a need to find alternative cheaper treatments than the combination therapies currently employed.

Other investigators have been unable to confirm the increase in T-cell-mediated immunity in healthy individuals following β-carotene supplementation. Santos et al. (1997) have recently reported the results of two studies in the elderly: a short-term high-dose study (90 mg/d for 21 d) in women and a longer-term lower-dose trial (50 mg on alternate days for 10–12 years) in men. Both studies concluded that there was no significant difference in T-cell function as assessed by DTH response, lymphocyte proliferation, IL-2 and prostaglandin E2 production, and composition of lymphocyte subsets. However, these workers also examined the effect of β-carotene supplementation on natural killer (NK) cell activity (important for tumour surveillance and eliminating viral infections) in the longer-term trial with male volunteers. Supplementation resulted in significantly ($P < 0.05$) greater NK cell activity compared with subjects of a similar age given placebo treatment (Santos et al. 1996). The study also highlighted the reduction in NK cell activity that is observed with age but, interestingly, the increase in NK cell activity observed in older males (65–86 years) following β-carotene supplementation restored this activity to the level seen in a group of younger males (51–64 years). Watson et al. (1991) undertook a variable-dose β-carotene supplementation study (0, 15, 30, 45 and 60 mg/d) in small numbers of men and women. They observed an increase in NK cell numbers (CD16+) following β-carotene supplementation of 30–60 mg/d for 2 months. However, after 2 months cessation of supplementation the values returned to baseline.

**β-Carotene and monocyte function**

Since cell-mediated immune responses are initiated by antigen-presenting cells, we have investigated whether β-carotene supplementation can influence blood monocytes (the main antigen-presenting cell type in the blood). A prerequisite for antigen-presenting cell function is the expression of MHC class II molecules (human leucocyte-associated antigen (HLA)-DR, HLA-DP and HLA-DQ; Bach, 1985), which are present on the majority of human monocytes. The antigenic peptide is presented to the helper T lymphocyte within a groove of the MHC class II molecule (Fig. 2). Since the degree of immune responsiveness of an individual has been shown to be proportional to both the percentage of MHC class II-positive monocytes and the density of these molecules on the cell surface (Janeway et al. 1984), it is possible that one mechanism by which β-carotene may enhance cell-mediated immune responses is by enhancing the cell surface expression of these molecules. In addition, cell-to-cell adhesion is critical for the initiation of a primary immune response, and it has been shown that the intercellular adhesion molecule-1 (ICAM-1)–leucocyte function-associated antigen-1 ligand–receptor pair is also capable of co-stimulating an immune response (Springer, 1990), enhancing T-cell proliferation and cytokine production. Thus, we examined the effect of β-carotene supplementation at a dietary achievable level (15 mg/d; equivalent to 150 g carrots) on the cell surface expression on blood monocytes of MHC class II molecules, and of several adhesion molecules known to be involved in the process of antigen presentation.

We undertook a double-blind placebo-controlled crossover study, in which twenty-five healthy adult male non-smokers were randomly assigned to receive β-carotene or placebo for 26 d, followed by the alternative treatment for a further 26 d. Following dietary supplementation there were significant increases ($P < 0.05$ in all cases) in plasma levels of β-carotene and in the percentages of monocytes expressing the MHC class II molecule, HLA-DR, and the adhesion molecules ICAM-1 and leucocyte function-associated antigen-3 (Hughes et al. 1997a). These results suggest that moderate increases in the dietary intake of β-carotene can enhance cell-mediated immune responses within a relatively short period of time, providing a potential mechanism for the anti-carcinogenic properties attributed to this compound. The increase in expression of these surface molecules may also, in part, account for the ability of β-carotene to prevent the reduction in DTH response following exposure to u.v. radiation, since the latter can inhibit both HLA-DR (Khan et al. 1993) and ICAM-1 (Tang & Udey, 1991) expression on human cell lines. This finding could certainly be relevant to the preventative action of β-carotene on the formation of skin cancer (Mathews-Roth, 1989), since immunosuppressed individuals, such as renal transplant patients, have an increased risk of skin cancer (Greenwald & Greenwald, 1983).

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**Fig. 2.** Cell surface molecules involved in the initiation of cell-mediated immune responses. (●), Antigen. LFA, leucocyte function-associated antigen; ICAM-1, intercellular adhesion molecule-1; HLA, human leucocyte-associated antigen; MHC, major histocompatibility complex.
Potential mechanisms of immune modulation

It is now appreciated that the transcription factor nuclear factor kappa B is required for maximal transcription of many inflammatory cytokines and adhesion molecules, including ICAM-1, and it is thought that the generation of reactive oxygen species is a vital link in mediating nuclear factor kappa B activation by a variety of stimuli (Sen & Packer, 1996; Jackson et al. 1998). Thus, it is possible that antioxidant nutrients can influence a variety of inflammatory processes by inhibiting nuclear factor kappa B activity. This factor might be a possible mechanism for the observed decrease in surface molecule expression on monocytes following supplementation with lutein, but the opposite effect of β-carotene cannot be explained by this process. One possible factor to explain the different effects seen with different carotenoids might be the preferred location of these compounds within the cell. Carotenoids are lipid soluble, and thus it is thought that most carotenoids will be concentrated in the lipid-rich membranes of the cell. However, their exact location may influence their effectiveness in modulating specific cellular events. To date, very little work has been undertaken to explore the distribution of individual carotenoids within mammalian cells.

An alternative mechanism of immunomodulation is suggested by the particular sensitivity of the immune system to oxidative stress. Peroxidation of the polyunsaturated fatty acids present in cell membranes can lead to a reduction in cell membrane receptor expression (Gruner et al. 1986). In addition, the production of reactive oxygen species by phagocytic immune cells can damage the cells themselves if they are not sufficiently protected by antioxidants. Thus, it is possible that antioxidants such as β-carotene might prevent oxidative damage to immune cell membranes, enhancing membrane integrity, and elevating the expression of cell surface molecules. It has been demonstrated that free radicals can suppress the expression of the major MHC class II molecule HLA-DR (Gruner et al. 1986), and we have recently shown that dietary supplementation with fish oil, containing n-3 polyunsaturated fatty acids which are more vulnerable to lipid peroxidation than are saturated fatty acids, inhibits the expression of HLA-DR and ICAM-1 on human monocytes (Hughes et al. 1996).

Changes in eicosanoid production can also influence the expression of cell membrane molecules. Prostaglandin E2 is the major eicosanoid synthesized by monocytes and macrophages, and is known to possess a number of immunosuppressive properties. For example, it can inhibit the expression of Ia molecules (the murine equivalent of human MHC class II molecules) on stimulated macrophages (Snyder et al. 1982). It has been suggested that one mechanism by which β-carotene might enhance immune responses is by altering the activation of the arachidonic acid cascade (from which prostaglandin E2 is derived), since β-carotene has been shown to suppress the generation of arachidonic acid products in vitro from non-lymphoid tissues (Haley & Sklan, 1987). This possibility requires further investigation.

Prospective studies of β-carotene supplementation

In terms of cancer prevention, the strongest epidemiological evidence supports a protective effect of β-carotene intake in preventing cancer of the lung. Carotenoid intake has been associated with a reduced lung-cancer risk in eight of eight prospective studies and in eighteen of twenty retrospective studies (Zeigler et al. 1996). As a result three major intervention trials were initiated, examining the efficacy of β-carotene in the prevention of lung cancer (The Alpha-tocopherol Beta-carotene Cancer Prevention Study Group, 1994; Hennekens et al. 1996; Omenn et al. 1996). The failure of these trials to show a protective effect, with two of
the studies showing an increase in lung cancer in smokers receiving β-carotene supplementation, has been widely publicized, although there remains some uncertainty as to whether the increased incidence of lung cancer seen in the Finnish study was restricted to a clinical sub-population of the participants.

The mechanism for the increased lung-cancer risk associated with the supplementation is unclear, but several suggestions have been made. Since the participants in these studies could be classified as ‘high-risk’ for developing lung cancer (long-term smokers or previously exposed to asbestos), it is possible that many of them had undetected tumours before the commencement of supplementation. The stage (or stages) of carcinogenesis at which β-carotene might be effective is unclear, but if the effect is mediated via the immune system it is likely to occur during the promotional stages preceding the formation of a malignant tumour.

The worrying possibility is that β-carotene might actually provide a protective effect to already established tumours. Tumour cells have an impairment in their antioxidant defences compared with normal cells (Toyokuni et al., 1995), and so they might particularly benefit from an increased supply of antioxidants. It has recently been shown that in vitro pre-incubation of tumour cells with various antioxidants, including β-carotene, can increase their resistance to lysis by NK cells (Riondel et al., 1998). In addition, in our dietary supplementation study we showed that β-carotene can enhance the production of tumour necrosis factor α, a pro-inflammatory cytokine with anti-carcinogenic properties. It has been suggested subsequently that β-carotene might also increase the production of other mediators such as IL-4 and IL-6 because of the increased binding of CD4+ T lymphocytes to MHC class II molecules, which might act as a promoter for existing neoplastic cells present in the lungs of smokers (Fernandes, 1997). However, this author also suggests that moderate β-carotene supplementation in healthy individuals could elevate tumour necrosis factor α production in a way which might up-regulate equally the MHC class I molecules and increase cytotoxic (CD8+) T and NK cell function, potentially suppressing further the initiation process of pre-neoplastic cells. This possibility highlights one of the major unresolved problems of β-carotene: i.e. what intake is required for optimal immune function and other healthy properties. Most studies of this compound have been undertaken at levels which are not achievable within a normal healthy diet. It is still unclear whether different intakes are associated with different outcomes or, in mechanistic studies, with different effects on various aspects of immune function. In addition, there remains the potentiality that, at higher intakes, β-carotene may exhibit pro-oxidant activity, particularly in the presence of high O2 tensions, as occurs in the lungs (for review, see Palozza, 1998).

**Concluding remarks**

There is no doubt that carotenoids, particularly β-carotene, can influence human immune cell function. However, they may differ in their effects, and the total dietary intake of carotenoids might be critical in determining their overall effect. Further research needs to be undertaken to establish the levels of intake required to optimize immune responsiveness in different groups of the population (e.g. the elderly and smokers) and to examine the interaction between carotenoids and other antioxidant nutrients. In addition, greater emphasis should be placed on studying the effects of enriching the diet with carotenoids via real food-stuffs rather than by supplementation.

**Acknowledgements**

The author would like to thank the Biotechnology and Biological Sciences Research Council and the Ministry of Agriculture, Fisheries and Food for financial support.

**References**


