The human oro-gastrointestinal (GI) tract is a complex system, consisting of oral cavity, pharynx, oesophagus, stomach, small intestine, large intestine, rectum and anus, which all together with the accessory digestive organs constitute the digestive system. The function of the digestive system is to break down dietary constituents into small molecules and then absorb these for subsequent distribution throughout the body. Besides digestion and carbohydrate metabolism, the indigenous microbiota has an important influence on host physiological, nutritional and immunological processes, and commensal bacteria are able to modulate the expression of host genes that regulate diverse and fundamental physiological functions. The main external factors that can affect the composition of the microbial community in generally healthy adults include major dietary changes and antibiotic therapy. Changes in some selected bacterial groups have been observed due to controlled changes to the normal diet e.g. high-protein diet, high-fat diet, prebiotics, probiotics and polyphenols. More specifically, changes in the type and quantity of non-digestible carbohydrates in the human diet influence both the metabolic products formed in the lower regions of the GI tract and the bacterial populations detected in faeces. The interactions between dietary factors, gut microbiota and host metabolism are increasingly demonstrated to be important for maintaining homeostasis and health. Therefore the aim of this review is to summarise the effect of diet, and especially dietary interventions, on the human gut microbiota. Furthermore, the most important confounding factors (methodologies used and intrinsic human factors) in relation to gut microbiota analyses are elucidated.

In the past 10 years, there has been a wealth of studies in which the relationship between the human gut microbiota and human health has been investigated. Moreover, recently there have been several human health-related microbiota studies with partly contradictory results regarding e.g. obesity-related microbiota and abundance of bifidobacteria in the faecal microbiota of babies. As it is likely that at least some of the differences may be explained by the methodology applied, it is of utmost importance that when reading articles related to human gut microbiota studies the most important confounding factors are known.

In an adult human individual, resident bacteria outnumber human cells by a factor of ten; each adult harbours on average $10^{13}$ mammalian cells and $10^{14}$ microbial cells. Most of the microbes, typically $10^{11}$–$10^{12}$ microbes/g, can be found in faeces and from the large intestine, which is considered to be a complex fermentor with a metabolic potential to rival that of the liver. The environmental determinants, namely temperature, pH, redox potential, atmospheric composition, water activity, salinity and light, within each region of the human oro-gastrointestinal (GI) tract are very

**Abbreviations:**  
GI, gastrointestinal; DF, dietary fibre; FISH, fluorescent in situ hybridisation; FOS, fructo-oligosaccharide; MZ, monozygotic.

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different, and therefore each region has its own distinctive microbiota. Since digestive enzymes are not secreted by the mucosa of the large intestine, further breakdown of dietary constituents is carried out by the resident microbiota. Carbohydrates are mainly fermented in the proximal colon, whereas the fermentation of proteins takes place mainly in the distal colon. The primary activity of the caecum and colon microbiota is the breakdown of carbohydrates not digested in the ileum to SCFA, which are then rapidly absorbed. The principal products of carbohydrate fermentation are SCFA (acetate, propionate and butyrate), hydrogen and CO₂, and bacterial cell mass (biomass). The amount of energy derived from SCFA accounts for up to 10% of the total energy requirement of human subjects. From a nutritional point of view, the SCFA are important since they not only provide energy but are also metabolised in different tissues.

The microbiota in the colon and faeces is extremely diverse and on the basis of estimations from culture-based and molecular studies more than 1200 prevalent bacterial species altogether reside there. Each individual harbours at least 160 such species. Under normal circumstances, predominant intestinal microbiota of an adult individual is fairly stable. However, in studies where the long-term temporal stability of the predominant microbiota has been assessed from healthy subjects, the number of subjects has been limited. The human GI-tract, although harbouring a vast number of microbes, has only a limited diversity at the phylum level. Microbes from seven bacterial phyla (Firmicutes, Bacteroidetes, Actinobacteria, Proteobacteria, Fusobacteria, Verrucomicrobia and Cyanobacteria-like) and one archael phylum (Euryarchaeota) have been detected in the human intestine. The majority of the GI-tract population are representatives of three phyla: the Firmicutes, Bacteroidetes, and Actinobacteria. Under normal circumstances, predominant intestinal microbiota of an adult individual is fairly stable. However, in studies where the long-term temporal stability of the predominant microbiota has been assessed from healthy subjects, the number of subjects has been limited. The human GI-tract, although harbouring a vast number of microbes, has only a limited diversity at the phylum level. Microbes from seven bacterial phyla (Firmicutes, Bacteroidetes, Actinobacteria, Proteobacteria, Fusobacteria, Verrucomicrobia and Cyanobacteria-like) and one archael phylum (Euryarchaeota) have been detected in the human intestine. The majority of the GI-tract population are representatives of three phyla: the Firmicutes, Bacteroidetes, and Actinobacteria. Under normal circumstances, predominant intestinal microbiota of an adult individual is fairly stable. However, in studies where the long-term temporal stability of the predominant microbiota has been assessed from healthy subjects, the number of subjects has been limited. The human GI-tract, although harbouring a vast number of microbes, has only a limited diversity at the phylum level. Microbes from seven bacterial phyla (Firmicutes, Bacteroidetes, Actinobacteria, Proteobacteria, Fusobacteria, Verrucomicrobia and Cyanobacteria-like) and one archael phylum (Euryarchaeota) have been detected in the human intestine. The majority of the GI-tract population are representatives of three phyla: the Firmicutes, Bacteroidetes, and Actinobacteria. Under normal circumstances, predominant intestinal microbiota of an adult individual is fairly stable. However, in studies where the long-term temporal stability of the predominant microbiota has been assessed from healthy subjects, the number of subjects has been limited.
Factors that affect the gut microbiota

There are several factors that affect the composition of the human GI microbiota, such as genetics, sex, ethnicity, age, medication, diseases/disorders and last but not least the diet.

Genetics of the host and geography

Twins, especially monozygotic (MZ) twins, have been reported to have more similar interindividual faecal microbiota than unrelated people. In addition, twins and their mothers have a more similar microbiota than unrelated individuals. These findings have led to the conclusion that the host genotype affects the development of the gut microbiota and gut bacterial composition\(^1\),\(^4\),\(^2\),\(^1\),\(^2\),\(^3\),\(^4\),\(^5\),\(^6\),\(^7\),\(^8\),\(^9\),\(^10\). However, the aforementioned studies have mainly been conducted with MZ pairs concordant for leanness or obesity. Simoes et al.\(^3\) studied MZ twins discordant for obesity, and found that the concordant normal-weight MZ twins had more similar bacterial populations than the MZ twins discordant for obesity. These findings also address the importance of the diet in addition to the genetic drivers\(^3\). Although the genetics or the shared environmental factors during upbringing result in more similar bacterial populations, viromes have been shown to be unique in individuals regardless of their degree of genetic relatedness\(^2\).

Besides genetics, the effect of the geographic origin (which may also include genetic differences and environmental sources of variation) has also been studied in relation to the gut microbiota composition. Even in Europe some differences may be found between different countries, e.g. proportions of bifidobacteria have been found to be 2- to 3-fold higher in an Italian adult study population than in other European study populations\(^5\),\(^6\),\(^7\),\(^8\). In addition, when 6-week-old infants across Europe were studied, geography was a more prominent factor than delivery mode, breast-feeding and antibiotics. In infants, children from Northern European countries had more bifidobacteria, whereas the Southern European infants were associated with more diverse microbiota and higher numbers of Bacteroides than the Northern European children\(^8\). In the studies involving people from different continents, the bacterial population differences have been more distinct. In a few recent studies, there have been consistent results that the European and North-American faecal microbiota differ significantly from the Southern-American, African and Chinese faecal microbiota\(^6\),\(^7\),\(^8\),\(^9\). However, in all of these studies it is not possible to exclude the impact of other possible confounding factors, and therefore dietary habits and genetics may also contribute to the differences.

Age

Bacterial colonisation of the infant GI tract is influenced by e.g. mode of delivery, prematurity, type of feeding (breast feeding v. formula feeding), antibiotic treatment of the child or the mother, lifestyle and geographics\(^5\),\(^6\),\(^7\),\(^8\),\(^9\). The earliest colonisers are usually facultative anaerobic bacteria such as Enterobacteriaceae,
streptococci and staphylococci, whereas later colonisers tend to be strict anaerobes e.g. bifidobacteria, clostridia and Bacteroides spp. regardless of the infant’s geographical origin and methods used for the detection(65,75-80). Immediately after birth, the rectal microbiota of vaginally delivered babies resembles their own mother’s vaginal microbiota, whereas the rectal microbiota of babies delivered by Caesarean section resembles that of the skin(81). The gut microbiota of preterm infants is less diverse than those of full-term babies(70,73,82-84). There are numerous studies in which the predominance of bifidobacteria in exclusively breast-fed infants has been found(65,66,74,83-88). At age 3–6 weeks, exclusively breast-fed infants harbour higher numbers of bifidobacteria, whereas formula-fed babies have more diverse microbiota, lower numbers of bifidobacteria and higher numbers of Bacteroides, Lachnospiraceae, Lactobacillus group, Clostridium difficile and Coriobacteriaceae(65,71,74,87,89,90). By the end of the first year of life, when the child has already started to eat the same foods as the adults, the gut microbiota starts to converge towards a profile characteristic of the adult microbiota(76,90). However, the faecal bacterial diversity is still lower. By the end of the second to third year, the phylogenetic composition evolves towards the adult-like composition(66,91).

The GI microbiota evolves with age(92). Dental deterioration, salivary function, digestion, slower intestinal transit time and changes in diet and physical activity may affect the GI microbiota of ageing people. Interest, as well as the number of studies, in the GI microbiota of elderly people has grown as life expectancy in the Western world has rapidly increased. The elderly have been reported to have relatively stable microbiota(93–95). However, the microbiota of the elderly has been reported to be more diverse and to contain partly different core microbiota as compared with younger adults(93,94,96,97). Moreover, inter-individual variation is greater in elderly people as compared with younger adults(2,94,98).

Medication

In addition to dietary components, the other important external factor affecting the microbiota is antibiotic use. However, different types of antibiotics have different types of action mechanisms and thus different effects on the human microbiota(99,100). In addition, individual human responses may be different. Bifidobacteria are typically susceptible to the majority of clinically relevant antibiotics such as penicillins (β-lactam antibiotics), cephalosporins and macrolides(101–108), and most of the commensal gut bacteria (e.g. bifidobacteria, Bacteroides spp.) to amoxicillin (β-lactam antibiotic) and clavulanate(102).

The effect of diet on human gut microbiota

The importance of the metabolic activities of the gut microbiota from the host’s perspective

From the host’s perspective, there are numerous activities of the commensal gut microbiota that are of great importance to health. Carbohydrates are mainly fermented in the proximal colon, whereas the fermentation of proteins takes place mainly in the distal colon. However, the metabolic output of the microbial community depends not only on available substrates, but also on the gut environment, with the pH playing a major role. For example, at pH 6.7 Bacteroides spp. predominate, whereas at pH 5.5 bacteria related to E. rectale predominate(107–109). The main saccharolytic genera in the human GI-tract are Bacteroides, Bifidobacterium, Clostridium, Eubacterium, Lactobacillus and Ruminococcus. The saccharolytic genera are able to produce SCFA, which have both local and systematic beneficial biological effects. A wide range of bacteria have proteolytic activities, such as clostridia, and species within genera Propionibacterium, Prevotella, Bifidobacterium and Bacteroides. Protein metabolism, however, is not as favourable to the host as carbohydrate metabolism; some of the end-products of amino acid metabolism may be deleterious to the host, e.g. ammonia, amines and phenol compounds. Some species of the genera Bacteroides, ruminococci and Akkermansia are able to break down mucin. Moreover, several Eubacterium spp. and Clostridium spp. are able to dehydroxylate bile acids, some Clostridium spp. transform conjugated bilirubin, Eubacterium coprostanoligenes is able to convert cholesterol to coprostanol and Bacteroides spp. inactivate tryptic activity, have dipeptidase activity and play a key role in the enterohepatic circulation of bile acids(103,104–114).

In addition to the individual activities, cross-feeding between the gut microbes and the metabolic networks thus created are also of great importance. For example, it has been shown in vitro that lactate produced by Bifidobacterium adolescentis as a fermentation product from fructo-oligosaccharide (FOS) and starch was further utilised by butyrate producers, which were not able to grow solely on FOS and starch(115). In addition, Roseburia intestinalis and Anaerostipes caccae were able to grow with Bifidobacterium longum using FOS; R. intestinalis was able to grow on the FOS-supplemented medium when acetate, a major fermentation product of B. longum, was added to the medium, whereas A. caccae was able to utilise fructose that was released during the bifidobacterial fermentation of FOS(116). Besides other survival mechanisms, gene transfer within and from outside the gut microbiota has also been shown to occur. In Japan, where consumption of marine algae is high, a Japanese gut bacterium (Bacteroides plebeius) has acquired genes coding for porphyrinomases, agarases and associated proteins and thus the ability to utilise marine algae. These algae are not readily fermentable by Western gut microbiota(117).

Dietary interventions vs. habitual diet

The main external factors that can affect the composition of the microbial community in generally healthy adults include major dietary changes and antibiotic therapy. Changes in some selected bacterial groups have been observed due to controlled changes to the normal diet e.g. high-protein diet(118,119), prebiotics(97,120–122),...
probiotics[123–125] weight-loss diet[20,126,127] and berries[128]. More specifically, changes in the type and quantity of non-digestible carbohydrates in the human diet influence both the metabolic products formed in the lower regions of the GI tract and levels of bacterial populations detected in faeces[129]. The interactions between dietary factors, gut microbiota and host metabolism are important for maintaining homeostasis and health[130,131].

The impact of habitual diet on faecal microbiota has been studied for decades. In older culture-based studies, it was found that numbers of bacteroides were lower and numbers of enterococci and Escherichia coli higher in Ugandan, Indian and Japanese people on a high-carbohydrate diet as compared with people on a Western diet[131,132]. However, when English people on a strictly vegetarian diet were studied, their microbiota resembled those of people on a Western diet more than the microbiota of other vegetarian people from different continents[133]. Similarly, numbers of bacteroides and clostridia were lower in the Nigerian Maguza tribal people (predominantly cereal diet) than in the other dietary groups[133]. In more recent molecular studies, in which gut microbiota from different parts of the world has been compared, a significant correlation between habitual diet and faecal microbiota has also been found. African children consuming a diet low in fat and animal protein and rich in starch, fibre and plant polysaccharides (predominantly vegetarian) had significantly more Bacteroidetes and Actinobacteria and less Firmicutes than omnivorous people[134,135], whereas vegans have lower faecal numbers of Bacteroides than omnivorous people[135,136] and numbers of bacteroides, proteobacteria and enterococci and also plays a major role in the regulation of cell proliferation and differentiation[7]. Several excellent review-papers already exist[130,142–147], and therefore we will not go into detail with the dietary interventions with fibre.

**Fermentable dietary carbohydrates**

Dietary components that escape digestion by endogenous enzymes in the upper GI tract become available substrates in the large intestine[7]. Dietary fibre (DF) is a normal constituent of most foods derived from plants[144]. These ‘non-digestible’ dietary carbohydrate substrates include resistant starch, plant cell-wall material (non-starch polysaccharides) and oligosaccharides[7]. In the human colon, DF is metabolised by the microbiota to SCFA, comprising mainly acetic, propionic and butyric acids. SCFA have been implicated to have both local and systemic beneficial biological effects in the human body; acetate is readily absorbed and transported to the liver; propionate is a substrate for hepatic glucose-neogenesis; butyrate is the preferred fuel of the colonocytes and also plays a major role in the regulation of cell proliferation and differentiation[7].

In vitro and in vivo evidence indicate that a bacterial group related to Faecalibacterium prausnitzii, Roseburia and E. rectale plays a major role in mediating the butyrogenic effect of fermentable dietary carbohydrates[107,148–150]. In addition, it has been shown in numerous studies that as dietary carbohydrate content is reduced in the diet the count of *F. prausnitzii* declines, respectively[129,151]. However, some lactate-utilising bacteria within Lachnospiraceae produce less butyrate in the presence of lactate-utilising sulphate-reducing bacteria. Moreover, in the presence of higher abundance of lactate, the formation of butyrate was reduced even more and the formation of hydrogen sulphide was promoted[152].
Cereal grains are a good source of DF. The main DF components of cereal grains are arabinoxylan, cellulose, β-glucan, fructan, resistant starch and lignin. The gut microbiota stimulating activities of arabinoxylan (stimulates *Bacteroides* spp. and *Roseburia* spp.), resistant starch (stimulates bifidobacteria, *Bacteroides* spp., *Ruminococcus bromii*, *E. rectale* and *Roseburia* spp.), β-glucan (stimulates bifidobacteria) and fructan (stimulates bifidobacteria, *Bacteroides* spp., lactobacilli and butyrate-producers) are well recognised. In addition, arabinoxylan-oligosaccharides, which are enzymatic hydrolysis products of arabinoxylan, have been shown to stimulate the growth of bifidobacteria in some studies. The effects of cellulose and lignin on gut microbiota are less well known. However, it should be noted that e.g. the size of the grain flakes may lead to different bacterial responses: i.e. smaller-sized whole-oat grain flakes (0.53–0.63 mm) resulted in a significant increase in the numbers of *Bacteroides–Prevotella* group bacteria, whereas in a fermentation with larger oat flakes (0.85–1.00 mm) bifidobacterial numbers increased. It has also been shown in *in vitro* model studies using different substrates that the majority of the bacteria attached to wheat bran belonged to Lachnospiraceae and some bacteria were *Bacteroides* spp., whereas *R. bromii*, *B. adolescentis*, *Bifidobacterium breve* and *E. rectale* were found attached to starch. When muncin was used as a substrate, the most commonly found bacteria were *Bifidobacterium bifidum* and an uncultured relative of *Ruminococcus lactaris*.

**Prebiotics**

Prebiotics are non-digestible (by the host) food ingredients that have a beneficial effect through their selective metabolism in the intestinal tract. The prebiotics that currently fulfil the prebiotic criteria are inulin, FOS, galacto-oligosaccharides and lactulose. The best sources of naturally occurring prebiotics may be found in vegetables such as artichokes, onions, chicory, garlic and leek. There are numerous studies in which the bifidogenic properties of prebiotics are shown. In addition, increase in abundance of lactobacilli and *F. prausnitzii* has been shown. Moreover, in infant formulas, galacto-oligosaccharides + FOS supplementation of cow’s milk-based formula has led to a bifidobacterial population which resembled more that of breast-fed infants than purely formula-fed infants. FOS have also positive effects on the intestinal barrier function.

**Protein**

Endogenous protein sources make up approximately one-third of the exogenous dietary protein pool. Bacterial amino acid catabolism in the human gut occurs via a number of mechanisms involving either deamination or decarboxylation reactions. The types of SCFA produced from amino acids are dependent on the chemical compositions of the substrates. In addition to SCFA, branched chain-fatty acids and aromatic compounds, namely phenol, indole and a range of phenolic and indolic substituted fatty acids derived from phenylalanine, tyrosine and tryptophan may be formed. Moreover, branched-chain amino acids are slowly fermented by colonic bacteria, with the main acidic products being branched chain-fatty acids one carbon atom shorter than the parent amino acid. Many metabolites produced by amino acid fermentation are harmful to the host. Phenolic and indolic compounds are also thought to act as co-carcinogens, while amines serve as precursors of nitrosamine production.

Culture-based studies have shown that the counts of *Bacteroides* spp. and clostridia increased significantly, whereas counts of *B. adolescentis* decreased significantly during a high-beef diet as compared with a meatless diet (fat and fibre contents were essentially the same in both diets). In addition, sulphide concentrations were high on a high-beef diet. Hydrogen sulphide is toxic to the colonic epithelium and sulphide inhibits butyrate oxidation, dietary sulphide may selectively stimulate the growth of a single group of bacteria, namely sulphate-reducing bacteria, with potentially harmful effects on the epithelium. In addition, an intervention diet with a high protein and low carbohydrate content reduced the numbers of *Roseburial/E. rectal* group, while increasing proportions of branched-chain fatty acids and concentrations of phenylacetic acid and *N*-nitroso compounds. Moreover, it should be noted that the World Cancer Research Fund released in May 2011 a report based on 1012 clinical trials, in which red and processed meat were convincingly associated with increased risk, whereas foods containing DF, in particular cereal fibre and whole grains, were associated with decreased risk of colorectal cancer.

**Fat**

Fats are composed of fatty acids that are divided into SFA and unsaturated fatty acids. Dietary SFA are mainly obtained from animal products, such as meats and dairy foods, but may also be obtained from some plant sources, such as coconut, cottonseed and palm kernel oils. The major dietary MUFA is oleic acid. Oleic acid is the primary component of olive oil, but may also be found in hazelnut, rapeseed and peanut oils. A carbon chain that contains two or more *cis* double bonds characterises the families of n-3 or n-6 PUFAs. These families cannot be synthesised by the human body. Linoleic (n-6 PUFA) and α-linolenic (n-3 PUFA) acids form the majority of PUFA in most Western diets. The long-chain n-3 PUFA EPA and DHA are found in seafood, especially oily fish.

High intake of dietary fat may increase the quantities of bile acids and fat that reach the colon. It has been suggested that the gut microbiota may metabolise dietary fats (producing diacylglycerols from polyunsaturated fats), convert primary bile acids into secondary bile acids and impact on the enterohepatic circulation of
bile acids and fat absorption from the small intestine\(^{183}\). However, there are only a few human studies in which the effect of high-fat diet on the human intestinal microbiota has been investigated, and especially those in which the correlations between the different types of dietary fat and intestinal microbiota have been investigated. In a study of Brinkworth et al.\(^{188}\), it was shown that a very low-carbohydrate, high-fat diet resulted in a significant reduction in bifidobacterial numbers, concentrations of butyrate and total SCFA, defecation frequency and faecal excretion as compared with isoenergetic high-carbohydrate, high-fibre and low-fat diet.

High MUFA-containing dietary intervention that lasted 4 weeks reduced the total bacterial numbers but did not affect the specific bacterial groups\(^{183}\). Conversely, high habitual intake of MUFA has been associated with lower numbers of bifidobacteria and slightly higher numbers of \textit{Bacteroides} spp\(^{64}\). In a recent metagenomic study in healthy volunteers, the \textit{Bacteroides} enterotype was found to be highly associated with the consumption of MUFA and SFA\(^{134}\). These observations suggest that the consumption of fat and animal-derived products, typically present in the Western diet, are associated with increased \textit{Bacteroides} spp. prevalence in the human gut microbiota.

Habitual \textit{n}-3 PUFA intake has been shown to have a significant positive association with \textit{Lactobacillus} group abundance\(^{64}\). The increase in \textit{Lactobacillus} group bacterial numbers in stool after \textit{n}-3 PUFA intake has also been reported in a mouse study\(^{185}\). In addition, in a human study by Santacruz et al.\(^{186}\) the numbers of lactobacilli remained at the same level, even though the ingested amount of total PUFA was greatly reduced. The increase in \textit{n}-3 PUFA is effective in supporting epithelial barrier integrity by improving transepithelial resistance and by reducing IL-4-mediated permeability\(^{187}\), and several lactobacilli enhance the function of the intestinal barrier\(^{188,189}\). Maternal salmon (marine \textit{n}-3 PUFA) consumption before delivery has also lowered the number of \textit{Coriobacteriaceae} in bottle-fed infants\(^{190}\).

Higher habitual \textit{n}-6 PUFA intake has been associated with decreased numbers of bifidobacteria\(^{64}\). It has also been reported that high \textit{n}-6 PUFA intakes decrease certain immune functions, such as antigen presentation, adhesion molecule expression, proinflammatory cytokines and T-helper 1 and T-helper 2 responses\(^{191}\). Furthermore, genomic DNA of some bifidobacterial strains is able to stimulate the production of T-helper 1 and proinflammatory cytokines, interferon-\(\gamma\) and TNF-\(\alpha\)\(^{192}\). Overall, these results indicate an association between dietary fat types and their distinct effect on the faecal microbiota. As a consequence, it seems that balanced diet with regard to fat consumption is critical not only for the host’s health, but also for the gut microbiota.

**Polymenols**

Plant foods contain significant amounts of phenolic compounds\(^{193}\). Plant polyphenols are a class of chemically diverse secondary metabolites that possess many different biological activities both within the plant and in the human subjects eating these plants. Plant polyphenols have the potential to affect certain risk factors of CVD, as well as being antioxidants, have antimicrobial properties and possessing inherent free radical scavenging abilities\(^{194}\). The main dietary sources of polyphenols are berries, fruits, beverages (e.g. coffee, tea and wine), chocolate, whole-grain cereals, vegetables and legume seeds\(^{193}\).

The human gut microbiota has extensive hydrolytic activities and breaks down many complex polyphenols into smaller phenolic acids, which can be absorbed across the intestinal mucosa\(^{194}\). Daily consumption of red wine polyphenols for 4 weeks significantly increased numbers of bacteria within genera \textit{Enterococcus}, \textit{Prevotella}, \textit{Bacteroides}, \textit{Bifidobacterium}, \textit{Eggerthella} and Family \textit{Lachnospiraceae}\(^{195}\), whereas consumption of high cocoa flavanol drink for 4 weeks significantly increased the bifidobacterial and lactobacilli numbers but significantly decreased clostridial counts\(^{196}\). Human dietary intervention with ellagitannins, which are polyphenols abundant in strawberries, raspberries and cloudberries, induced changes in the composition of \textit{Lachnospiraceae} and \textit{Ruminococcaceae}\(^{197}\). Tea polyphenols (e.g. epicatechin, catechin, gallic acid and caffeic acid) significantly repressed certain bacteria such as \textit{Clostridium perfringens} and \textit{C. difficile} and members of the \textit{Bacteroides} spp., whereas bifidobacteria, \textit{Lactobacillus} spp. and nonpathogenic \textit{Clostridium} spp. were less severely affected\(^{197}\). Moreover, many phenolic compounds have \textit{in vitro} anti-microbial activities towards pathogenic bacteria, such as \textit{Salmonella} spp., \textit{C. perfringens}, \textit{C. difficile}, \textit{E. coli} and \textit{Staphylococcus aureus}\(^{197-199}\).

**Probiotics**

Probiotics are live micro-organisms which when administered in adequate amounts confer a health benefit on the host, according to the widely accepted definition by Food and Agriculture Organisation WHO\(^{200}\). Most of the currently used probiotics belong to the genera \textit{Bifidobacterium} and \textit{Lactobacillus}. However, probiotic preparations containing species of the genera \textit{Enterococcus}, \textit{Pediococcus}, \textit{Streptococcus}, \textit{Lactococcus}, \textit{Propionibacterium}, \textit{Bacillus} and \textit{Saccharomyces} are also used\(^{201}\). The past two decades have seen a marked increase in the inclusion of probiotic bacteria in various types of food products, especially in fermented milks\(^{202}\). During recent years probiotics have also been increasingly incorporated into non-dairy foods such as fruit and berry juices and e.g. cereals\(^{201}\). In good quality products, the daily dose should be approximately 10\(^7\) colony-forming units/d\(^{203}\). Probiotics do not usually colonise the GI tract, and therefore the products should be consumed daily for the health benefits\(^{167}\). In most of the studies, probiotics have not caused any significant changes in the predominant faecal microbiota of healthy adults. However, there are very few studies in which e.g. \textit{Lactobacillus rhamnosus} GG has modulated...
the faecal microbiota and increased overall bacterial diversity in infants\textsuperscript{[123,204]}. In addition, \textit{Bifidobacterium animalis} subsp. \textit{lactis} Bb12 has reduced the numbers of Enterobacteriaceae and \textit{Clostridium} spp. in preterm infants\textsuperscript{[124]}.

Conclusions

To answer the question posed in the title: does diet matter in regard to human microbiota? Yes, it does. From the host’s perspective, there are numerous activities of the commensal gut microbiota that are of great importance to health. Moreover, by choosing what we eat, we can decide which bacteria we feed. However, even though diet matters, the results from dietary interventions are not always straightforward. It should be remembered that the detected effect is dependent on the study subjects, study protocols, used DNA-extraction techniques, used methodologies, and in case of next-generation sequencing also the algorithms used for cleaning and analysing the data. In addition, individual variation in human intestinal microbiota is so wide that the subtle changes may not be detected if the study cohort is not large enough. Therefore, studies in which different habitual diets have been compared with each other, usually get clearer correlations with nutrients vs. bacteria than those observed in dietary interventions.

In order to get as much information from future dietary interventions there would be need for big enough group sizes, long enough trials, long enough wash-out periods in cross-over designs, sufficient background information (i.e. baseline 7-d food records and clinical parameters) and last but not least more interdisciplinary research across microbiology, nutrition, immunology, genetics, epigenetics, proteomics, transcriptomics, metabolomics and human physiology.

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Conflicts of Interest

None.

Authorship

J. M. drafted the manuscript and undertook the literature searches. M. S. reviewed the literature on polyphenols, proteins and fats. J. M. and M. S. reviewed and revised the manuscript.

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