Efficacy and safety of dietary supplements containing CLA for the treatment of obesity: evidence from animal and human studies

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Abstract  Dietary supplements containing conjugated linoleic acid (CLA) are widely promoted as weight loss agents available over the counter and via the Internet. In this review, we evaluate the efficacy and safety of CLA supplementation based on peer-reviewed published results from randomized, placebo-controlled, human intervention trials lasting more than 4 weeks. We also review findings from experimental studies in animals and studies performed in vitro. CLA appears to produce loss of fat mass and increase of lean tissue mass in rodents, but the results from 13 randomized, controlled, short-term (<6 months) trials in humans find little evidence to support that CLA reduces body weight or promotes repartitioning of body fat and fat-free mass in man. However, there is increasing evidence from mice and human studies that the CLA isomer trans-10, cis-12 may produce liver hypertrophy and insulin resistance via a redistribution of fat deposition that resembles lipodystrophy. CLA also decreases the fat content of both human and bovine milk. In conclusion, although CLA appears to attenuate increases in body weight and body fat in several animal models, CLA isomers sold as dietary supplements are not effective as weight loss agents in humans and may actually have adverse effects on human health.—Larsen, T. M., S. Toubro, and A. Astrup. Efficacy and safety of dietary supplements containing CLA for the treatment of obesity: evidence from animal and human studies. J. Lipid Res. 2003. 44: 2234–2241.

Supplementary key words  fat mass • fat-free mass • insulin resistance • trans-10, cis-12 • clinical trial

DIETARY SOURCES OF CONJUGATED LINOLEIC ACID

Conjugated linoleic acid (CLA) is a collective term used to describe the mixture of positional and geometric isomers of linoleic acid with conjugated double bonds (i.e., the two double bonds are separated by one single bond).

The double bonds, each of which may be in the cis or trans configuration, can be in any position on the carbon chain. They are, however, most frequently found in positions 8 and 10, 9 and 11, 10 and 12, or 11 and 13. CLA is marketed commercially in the US in products such as Natrol®, Your Life®, Vitamin World®, Nature’s Way®, and Nature’s Plus®. These products are available over the counter in supermarkets, drug stores, and health food stores, and can be bought from wholesalers throughout the US. CLA is also sold in Asia, Canada, Europe and Japan (1). Most of the CLA products sold as dietary supplements for human consumption contain 60–90% CLA in the form of either free fatty acids or triglycerides, and they usually contain a mixture of isomers, predominantly cis-9, trans-11 (c9,t11) and trans-10, cis-12 (t10,c12) isomers (2).

The major sources of CLA in the human diet are meat and dairy products derived from ruminants, and in these products the predominant CLA isomer (>90%) is c9,t11. The amount of CLA present in dairy products varies according to the animal breed and the processing of the product, but the major determinant appears to be livestock feeding conditions (3, 4). Various livestock feeding strategies have been used for increasing the CLA content of cow’s milk. Data on CLA content of animal food products have recently become available, allowing estimation of human intakes. Recent studies suggest average intakes of ~150–200 mg/day (5, 6), and consumption of a diet rich in high-fat animal products can increase the daily intake to at least 650 mg/day (7). In comparison, CLA dietary supplements marketed for weight loss purposes constitute an intake of 3–4 g/day (8). Dietary CLA is recovered in human milk, serum lipids, and in adipose tissue. A sig-

Abbreviations:  CLA, conjugated linoleic acid; c9,t11, cis-9, trans-11; DXA, dual-energy X-ray absorptiometry; FFM, fat-free mass; FM, fat mass; MUFA, monounsaturated fatty acid; SCD1, stearoyl-CoA desaturase 1; SFA, saturated fatty acid; t10,c12, trans-10, cis-12; TG, triglyceride.

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significant correlation between the proportion of c9,t11 CLA in adipose tissue and milk fat intake has been found, and c9,t11 CLA can comprise 0.5% by weight of total fatty acids in human adipose tissue (5).

**ISOMER-SPECIFIC EFFECTS OF CLA ON BODY COMPOSITION**

CLA has been studied extensively in various animal species, and in general, it is now widely recognized that feeding CLA (various mixtures of isomers) to different animals (including mice, hamsters, rats, chickens, and dogs) results in changes in body composition, i.e., lowering of body weight and fat mass (FM) and a relative increase in lean body mass [as reviewed in ref. (9)]. For example, 6 weeks' administration of CLA (1% CLA added by weight to a low-fat diet, ~1.5g CLA/kg body weight) has been shown to decrease body weight by ~10% and body fat by ~70% when compared with placebo in mice (10). Furthermore, it has been shown, using accurate dual energy X-ray scanning methods, that CLA dose-dependently decreases fat accretion in growing pigs (11).

It appears that the effects on body composition are largest when CLA is given to the animal during growth periods, but the effects also depend on several other factors, including species, age, gender, dosage, and duration of CLA feeding, but perhaps most importantly, the CLA isomer composition. In the majority of the animal studies performed, the CLA preparations used have been mixtures of CLA isomers, i.e., usually a mixture composed of 30–40% of each of the c9,t11 and t10,c12 isomers, the residue consisting of various less-common isomers. Although CLA has effects when given as a mixture, recent studies in mice and hamsters have identified the t10,c12 isomer, rather than the c9,t11 isomer, as being responsible for the attenuation of body weight gain and for the reduction of body fat (12, 13). In a study on Zucker Diabetic Fatty (ZDF) rats, c9,t11 CLA had no significant effects, whereas a mixture of c9,t11 and t10,c12 lowered body weight, although this was partly a result of a decreased energy intake (14).

**EFFECTS OF CLA ONATHEROSCLEROSIS AND GLUCOSE TOLERANCE IN ANIMALS**

In general, the CLA-induced changes in cardiovascular risk factors, glucose tolerance, blood levels of free fatty acids, triglycerides, total-, LDL-, HDL- and/or VLDL-cholesterol, and liver metabolism observed in the various animal studies are conflicting.

There is considerable evidence that feeding CLA may affect liver metabolism and have adverse effects on glucose homeostasis in mice. Early studies in mice found that CLA induces peroxisome proliferation in the liver (15). In mice and chickens, CLA supplementation has been associated with increases in liver weight, possibly as a result of triglyceride accumulation (16–18).

In hamsters, the t10,c12 isomer causes enlargement of both liver and kidney, despite a lower body weight (19). In rats, however, CLA does not act as a classic peroxisome proliferator, despite moderate increases in liver weight (20–22).

Positive findings awakened interest in the health benefits of CLA. It was found that feeding rabbits a CLA mixture caused a substantial regression of established atherosclerosis, despite a significant increase in serum total cholesterol and decrease in HDL-cholesterol (23). However, others have found an increase in arterial fatty streak formation in c57BL/6 mice after CLA supplementation (24). Normalization of impaired glucose tolerance (using a glucose tolerance test) has been shown in Zucker rats fed a mixture of CLA (25), and the t10,c12 isomer has been shown to lower body weight and attenuate the development of insulin resistance in rats, though partly as a result of a decreased energy intake (14, 26). In contrast, CLA supplementation has been found to increase serum insulin levels in rats (27).

In mice and hamsters, CLA supplementation has been associated with increases in plasma insulin levels (10, 28). Similarly, despite resulting in decreased body weight, t10,c12 supplementation in mice was associated with increased serum glucose and insulin levels, whereas the c9,t11 supplementation group showed no weight loss, but lowered triglycerides and FFA (29). This study is in line with other studies in mice showing that CLA supplementation (36% t10,c12 isomer) results in marked reductions in body fat, although this was associated with the development of insulin resistance, resulting in a metabolic state resembling lipoatrophic diabetes (30, 31). Similar observations have been reported by other researchers, showing that mice fed purified t10,c12 CLA or CLA mixtures develop hyperinsulinemia and fatty liver (29, 32–34). However, the degree of fatty liver may depend to some extent on the total amount of fat in the diet, i.e., a higher dietary total fat content is associated with a lower degree of hepatic steatosis (20, 31).

**THE T10,C12 ISOMER AFFECTS FATTY ACID METABOLISM AND LIPID SYNTHESIS**

There is accumulating evidence that CLA may regulate lipid metabolism in addition to its effects on body composition per se. The t10,c12 isomer has been shown to inhibit the transcription and activity of stearoyl-CoA desaturase 1 (SCD1) in porcine adipose tissue in ex vivo studies (35). SCD1 desaturates saturated fatty acids (SFAs) into monounsaturated fatty acids (MUFSAs), resulting in a higher Δ-9 desaturase index, i.e., a higher MUFA/SFA ratio. In vitro studies have also delineated isomer-specific effects on SCD1 activity. The t10,c12 isomer seems to inhibit the expression of SCD1 mRNA in liver cells from mice fed the isomer and in mice liver cell lines, leading to decreased C16:1/C16:0 and C18:1/C18:0 ratios (36). Similarly, t10,c12 decreased SCD1 mRNA expression and activity in 3T3-L1 adipocytes, and resulted in cells with smaller lipid droplets.
The mechanism of action of the peripheral body fat-decreasing effects of CLA has not yet been fully elucidated. CLA does not seem to enhance energy expenditure acutely, but has been shown to increase energy expenditure in mice fed CLA for 6 weeks, despite a significant weight loss (10, 49). There is also controversy as to whether CLA affects energy intake, and some studies suggest that CLA may induce feeding aversion in mice (10) and rats (14); yet CLA seems to have effects on body composition in mice independent of changes in energy intake (50).

Despite these suggestions that an increased energy expenditure and a decreased energy intake occur with CLA intake, most of the evidence suggests that the major part of the effect on body fat changes can be explained by the attenuation of fat cell differentiation by the t10,c12 isomer. In vitro studies of primary cultures of stromal vascular cells from human adipose tissue have shown that t10,c12 can lower triglyceride incorporation in these cells (i.e., inhibit lipogenesis), whereas the e9,t11 isomer increases the triglyceride content (51, 52). Similarly, the t10,c12 isomer has consistently been shown to decrease the differentiation of 3T3-L1 adipocytes, possibly via a decrease in the expression and/or activation of the peroxisome proliferator-activated receptor γ, which is a strong inducer of adipocyte differentiation (53, 54). Several in vivo studies support these findings. Sprague-Dawley rats have been seen to have a decreased body weight, with the reduced FM apparently accomplished by a decrease in adipocyte cell size, rather than cell number, when fed a CLA mixture (55). However, others have reported that CLA supplementation may inhibit both adipocyte number and adipocyte size in mice (56, 57). Finally, the t10,c12 isomer has been shown to induce apoptosis in mouse adipose tissue (30, 50, 57).

THE EFFICACY AND SAFETY OF CLA IN HUMAN INTERVENTION STUDIES

Literature and data on human clinical trials with CLA supplementation for the present review were obtained from searching ISI Web of Science, MEDLINE, Science Citation Index, and patent databases, with the key words human, conjugated linoleic acid and CLA (latest access July 10, 2003). Other data sources include published indexes, patent databases (accessed at www.uspto.gov), abstract booklets, and references identified from bibliographies of pertinent articles and books.

Our initial search identified 19 randomized, double-blinded, placebo-controlled studies on CLA supplementation in humans where changes in body weight or body composition had been reported. Of the studies found, 12 are published in peer-reviewed journals, while seven are only reported in abstract form. Of these 19 studies, 12 studies met the selection criteria (duration of >4 weeks, published in peer-reviewed journals). A thirteenth study did not meet the selection criteria but was included due to its duration—a 6-month study by Atkinson (58) had the longest duration of all but was not published in a peer-reviewed journal. The studies were not eligible for a formal meta-analysis, due to insufficient reporting of important data and substantial differences in design. For example, the studies found differed significantly in CLA-isomer composition and dosage, study duration, subject characteristics, and measurement methods. The studies were therefore interpreted individually, and comparisons between studies had to be conducted with caution, inasmuch as they differed in several aspects. Whenever possible only P values <0.05 for the treatment effect between study groups (CLA vs. placebo) are considered and presented as significant effects. The findings of the 13 selected studies are summarized in Table 1.

No effect of CLA consumption on body weight was found in any of the 13 studies. FM was assessed in 10 studies, and three of these found a decrease in FM. Fat-free
<table>
<thead>
<tr>
<th>Study Subjects (Women/Men)</th>
<th>Intervention Period and Dose</th>
<th>CLA Composition and Provider</th>
<th>Placebo Supplementation</th>
<th>Author Conclusion</th>
<th>Blood Lipids or Other</th>
<th>Comments</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Subjects (17/0) BMI ~22</td>
<td>64 Days 5.9 g/day</td>
<td>65% CLA t10,c12, 22.6%; e9,t11,17.6%; c11,t13, 23.6%; c8,t10,16.6%; e9,t11+t10,t12, 7.7%; others; 11.9%; Tonalin™, Pharmanutrients, Inc</td>
<td>Sunflower oil (73% linoleic acid)</td>
<td>No effect on BW, FFM, or FM.</td>
<td>No change in lipids.</td>
<td>FM determined by bioimpedance and DXA.</td>
<td>(75, 76)</td>
</tr>
<tr>
<td>20 Subjects (10/10) BMI ~23</td>
<td>12 Weeks 1.8 g/day</td>
<td>60% CLA t10,c12, ~50%; e9,t11, ~50%; Tonalin™, Natural ASA</td>
<td>Hydrogel (1.8 g/day)</td>
<td>No effect on BW.</td>
<td>Decrease in FM.</td>
<td>NA</td>
<td>(77)</td>
</tr>
<tr>
<td>53 Subjects (26/27) BMI ~25</td>
<td>12 Weeks 4.2 g/day</td>
<td>75.9% CLA t10,c12, ~50%; e9,t11, ~50%; others; Minor Natural ASA</td>
<td>Olive oil (4.2 g/day)</td>
<td>No effect on BW.</td>
<td>Decrease in FM.</td>
<td>NA</td>
<td>(62, 78)</td>
</tr>
<tr>
<td>22 Subjects (10/14) BMI ~23</td>
<td>8 Weeks 0.7-1.4 g/day</td>
<td>69% CLA t10,c12, 51%; e9,t11, 49% CLA 70; Tredocell</td>
<td>Soybean oil</td>
<td>No effect on BW</td>
<td>Decrease in HDL.</td>
<td>FM determined by skin fold thickness.</td>
<td>FFM NA.</td>
</tr>
<tr>
<td>52 Subjects (55/17) BMI ~29</td>
<td>12 Weeks 1.7-6.8 g/day</td>
<td>75% CLA t10,c12, ~50%; e9,t11, ~50%; Tonalin™, Natural ASA</td>
<td>Olive oil (9 g/day)</td>
<td>No effect on BW or FFM.</td>
<td>Decrease in FM (CLA groups compared with placebo).</td>
<td>NA</td>
<td>(80)</td>
</tr>
<tr>
<td>24 Subjects (0/24) BMI ~32</td>
<td>4 Weeks 4.2 g/day</td>
<td>75% CLA t10,c12, ~37.6%; e9,t11, 36.9% CLA 80; Natural ASA</td>
<td>Olive oil (4.2 g/day)</td>
<td>No effect on BW.</td>
<td>Decrease in sagittal abdominal diameter.</td>
<td>NA</td>
<td>(81)</td>
</tr>
<tr>
<td>60 Subjects (0/60) BMI ~30</td>
<td>12 Weeks 5.4 g/day</td>
<td>j) Isomer mixture, 80%; CLA t10,c12, 35%; e9,t11, 35.4%; 2) t10c12 preparation, 75% CLA t10,c12, 76.5%; e9,t11, 2.9%; Natural ASA j) Tonalin™, Natural ASA</td>
<td>NA</td>
<td>No effect on BW, FM, or FFM.</td>
<td>Isomer mixture decreased HDL, t10,c12 decreased HDL, increased glucose and CRP, and decreased insulin sensitivity.</td>
<td>FM and FFM determined by bioimpedance.</td>
<td>(60, 61)</td>
</tr>
<tr>
<td>60 Subjects (NA) BMI ~30</td>
<td>12 Weeks 3.4 g/day</td>
<td>75% CLA Composition, NA; Tonalin™, Natural ASA</td>
<td>Olive oil (4.5 g/day)</td>
<td>No effect on BW, FM, or LBM.</td>
<td>No change in lipids.</td>
<td>FM and FFM determined by bioimpedance.</td>
<td>(64)</td>
</tr>
<tr>
<td>25 Subjects (NA) BMI ~30</td>
<td>28 Days 6 g/day</td>
<td>65% CLA Composition = Reference (75); Tonalin™, Pharmanutrients</td>
<td>Olive oil (9 g/day)</td>
<td>No effect on BW, FM, or FFM.</td>
<td>No change in lipids.</td>
<td>Exercise study. FM and FFM determined by DXA.</td>
<td>(82)</td>
</tr>
<tr>
<td>51 Subjects (23/28) BMI ~25</td>
<td>8 Weeks 5.0 g/day</td>
<td>j) 67% CLA, 50:50 mix; e9,t11, 50%; t10,c12, 50%; 2) 50% CLA, 80:20 mix; e9,t11, 80%; t10,c12, 20%; Loders Croklaan B.V.</td>
<td>Linoleic acid (3 g/day)</td>
<td>No effect on BW.</td>
<td>50:50 Mix reduced fasting TG. 80:20 Mix reduced VLDL. No change in glucose.</td>
<td>FM and FFM NA.</td>
<td>(83)</td>
</tr>
<tr>
<td>21 Subjects (NA)</td>
<td>8 Weeks 8 g/day</td>
<td>76% CLA t10,c12, 39%; e9,t11, 37%; Pharmanutrients</td>
<td>Safflower oil (8 g/day)</td>
<td>No effect on BW.</td>
<td>Decrease in fasting glucose.</td>
<td>FM and FFM NA.</td>
<td>(84)</td>
</tr>
<tr>
<td>80 Subjects (NA) BW = 94 kg</td>
<td>6 Months 2.7 g/day</td>
<td>NA</td>
<td>NA</td>
<td>No effect on BW, FM, or FFM.</td>
<td>No change.</td>
<td>Weight loss study. FM and FFM determined by underwater weighing.</td>
<td>(58, 63)</td>
</tr>
<tr>
<td>56 Subjects (26/28) 25&lt;BMI&lt;30</td>
<td>13 Weeks 1.8 or 3.6 g/day</td>
<td>CLA 75% TG; Tonalin™, Natural ASA, Hovdebygda</td>
<td>Oleic oil (1.8 or 3.6 g/day)</td>
<td>Increased regain of FFM. No effect on BW or % BW regain.</td>
<td>No change in glucose, insulin, or TG.</td>
<td>Weight loss/regain study. FM and FFM determined by hydrodensitometry and deuterium dilution.</td>
<td>(59)</td>
</tr>
</tbody>
</table>

BMI, body mass index; BW, body weight; e9,t11, cis9, trans-11; CLA, conjugated linoleic acid; DXA, dual-energy X-ray absorptiometry; FFM, fat-free mass; FM, fat mass; NA = not available; NIR, near-infrared technique; t10,c12, trans-10, cis-12; TG, triglycerides.

* Significance level for difference between CLA and placebo groups set at P < 0.05.
mass (FFM) was assessed in seven studies, but only one of these studies found a slight increase in body FFM (59) (FFM assumed to correspond to lean body mass). Three studies assessed neither FM nor FFM. With respect to cardiovascular risk factors, either no or very small changes in cholesterol levels were reported, and no consistent changes were observed.

Only one study included direct insulin sensitivity measurements. In this study by Riserus et al., for 12 weeks, supplementation with 3.4 g/day of purified (75%) t10,c12 resulted in a significant decrease in insulin sensitivity (using an intravenous glucose tolerance test), an increase in fasting plasma glucose, and a significant increase in the concentration of C-reactive protein, a marker of inflammation and a strong predictor of cardiovascular risk (60, 61).

CLA supplementation in humans has been shown to increase urinary levels of 8-iso-PGF2-α and 15-keto-dihydro-PGF2-α, which are in vivo markers of nonenzymatic and enzymatic lipid peroxidation and oxidative stress, processes that may contribute to insulin resistance (62).

To summarize, the present data from human trials does not support any weight loss-inducing effect of CLA, and there is no unequivocal evidence of an effect on body fat percentage. In addition, it seems that CLA may actually induce adverse effects, including insulin resistance, in subjects susceptible to type 2 diabetes.

**DISCUSSION**

CLA supplements sold as slimming agents over the counter and via the internet do not seem to affect body weight in humans, contrary to results from animal studies and in contrast to the claims made in the commercials promoting the products. It should be noted that many animal studies have used direct measures of body composition (i.e., weighing of individual organs after slaughter), whereas human studies have used indirect measures, such as bioimpedance or dual-energy X-ray absorptiometry (DXA) scanning. Whether these methodological differences also play a role in the apparent differences between animal and human studies regarding changes in body composition is unknown.

Also, when comparing animal and human studies, it should be noted that the doses of 25–80 mg/kg/day CLA used in humans are much lower than those used in animals, i.e., one-tenth of the dose given to pigs and often only approximately one-fiftieth of that given to rats per kg body weight (63). The efficacious doses used in rat studies would correspond to a daily CLA intake of 130g/day in humans. However, the cases of liver hypertrophy and insulin resistance reported in many animal studies using large doses of CLA indicate major concerns about administering higher doses of CLA to humans. One recent study of a 3.4 g/day CLA supplementation (CLA mixture) in humans found no effect on body composition and no adverse effects on a broad selection of traditional liver parameters and plasma lipids (64). However, some data suggest that CLA preparations may actually decrease fat deposition in adipose tissues. It can therefore be argued that efficacious doses (i.e., high enough to cause changes in body composition) may lead to higher blood lipid levels, succeeded by increased fat deposition in other tissues such as liver and/or muscle. Assuming that total energy intake and fat oxidation remain unchanged, this could possibly lead to some degree of lipotoxicity and insulin resistance.

There is increasing evidence that a high intake of trans fatty acids adversely affects the plasma lipid profile, increasing the LDL/HDL ratio, and may increase the risk of cardiovascular disease (65). CLAs should be classified structurally as trans fatty acids, and thus it could be argued that CLA may cause an increased cardiovascular risk. However, despite recent evidence that high levels of trans isomers of linoleic acid (identified as trans-C18:2, i.e., 9c,12t or 9t,12c fatty acids) in red blood cell membranes are associated with increased risk of primary cardiac arrest (66), further studies are required to evaluate whether CLA (or t10,c12) could exert similar effects.

Studies in rats and in vitro studies have suggested that CLA may decrease insulin resistance in a manner similar to that of the thiazolidinedione (TZD) class of insulin-sensitizer compounds, acting through stimulation of the peroxisome proliferator-activated receptor γ (67, 68). However, TZD drugs ameliorate insulin resistance by enhancing adipocyte differentiation and by depleting TG and FFAs from the blood while inducing body fat gain (69, 70), whereas CLA seems to induce a reduction in body fat in animal models. Thus, conditions with increased lipid supply to fat tissues may not necessarily lead to insulin resistance. In one study, transgenic mice with overexpression of phosphoenolpyruvate carboxykinase (a positive regulator of glyceroenogenesis in adipose tissue) developed obesity, but unlike other mice models, these obese mice did not develop insulin resistance (71). In contrast, transgenic mice with selective overexpression of lipoprotein lipase (a rate-controlling enzyme involved in triglyceride hydrolysis in liver and muscle) did not become obese but had an accumulation of intracellular fatty acid-derived metabolites in liver and muscle and subsequent insulin resistance in these tissues (72). Hence, the site of lipid deposition is an important determinant of the development of abnormal lipid metabolism.

While there is circumstantial evidence that CLA isomers may affect lipid metabolism and decrease body fat gain, suggestions that CLA supplementation may be used to treat type 2 diabetes (67, 68) may be overly optimistic, in particular in light of the significant decrease in insulin sensitivity found after t10,c12 supplementation for 12 weeks (60).

Furthermore, it has recently been shown that the quality of the commercially available CLA products is highly variable, in that the actual content of the various CLA isomers in the tablets varies substantially among the different preparations studied (73, 74). Finally, commercial CLA products (often CLA mixtures with high content of the c10,t12 isomer, together with other isomers) are usually considered dietary supplements. However, knowing that the natural dietary sources usually contain high levels of...
the t9,c11 isomer and very low levels of the c10,t12 isomer, whether this is an appropriate classification should be reconsidered.

To evaluate the potential beneficial/adverse effects of CLA supplementation accurately, it is requisite that the isomer distributions in the CLA preparations used be standardized.

Studies conducted to date have several shortcomings, such as small sample sizes, insufficient control of the isomeric composition of the CLA preparation, and imprecise assessment of body composition; insulin sensitivity was measured in only one study. When evaluating the outcome of a study, it should be emphasized that any beneficial changes in body weight/body composition should be associated with beneficial findings on type-2 diabetes and/or cardiovascular risk factors. Long-term, large-scale studies including better estimates of body composition (e.g., DXA scanning) and indices of insulin sensitivity and cardiovascular fitness (e.g., arterial compliance) are required before firm conclusions can be drawn.

In conclusion, the evidence from human short-term studies suggests that CLA supplementation does not reduce body weight and body fat or increase FFM. There is evidence that CLA isomers sold as dietary supplements have marked biological effects, but there is accumulating evidence that CLA isomers sold as dietary supplements do not improve nutritional status of tumor-bearing rats. CLA supplementation for humans should not be recommended before studies showing more positive findings are available.

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REFERENCES


