



LIFEPAK[®]

Healthcare Professional Product Guide

(Revision, January 2001)

Summary

LifePak is a comprehensive multi-vitamin/mineral/phytonutrient supplement designed to promote general health and well-being. LifePak addresses all common nutrient deficiencies, provides the key anti-aging nutrients that promote cellular protection and regeneration, and supports cardiovascular health, bone metabolism, insulin and blood glucose metabolism, and normal immune function. LifePak's antioxidant and cardiovascular benefits are supported by two double-blind clinical studies. LifePak is intended for the general adult population, and comes in two packets of four capsules each, to be taken with the morning and evening meals. All individual nutrient levels in LifePak are documented safe, and clinical studies showed no adverse effects due to LifePak supplementation. Pregnant or lactating women, or individuals with known medical conditions should consult a physician before using dietary supplements.

What is LifePak?

LifePak is a comprehensive dietary supplement, providing all essential vitamins and minerals, as well as antioxidant nutrients and phytonutrients, in optimum amounts to promote long-term health and general well-being. LifePak is intended for healthy adults in general. Pharmanex also offers LifePak Women for premenopausal women, LifePak PreNatal for pregnant and lactating women, and LifePak Prime for men over age 40 and postmenopausal women. This monograph covers regular LifePak.

Mechanism of Action

As a comprehensive nutritional multi-component product, LifePak has multiple mechanisms of action, which are described below whenever appropriate.

Scientific Studies

Clinical Studies.

The ingredients of LifePak—vitamins, minerals, and phytonutrients—are supported by hundreds of well-designed clinical studies. Many of these studies are referenced in the Health Benefits section below.

Unlike other multivitamin/mineral products, LifePak is also supported by two double-blind, placebo-controlled clinical studies, a 140-subject parallel design study and a 46-subject crossover study. Both studies tested the antioxidant effects of LifePak in healthy non-smokers.

In the completely randomized crossover study (1), a total of 50 healthy non-smokers were enrolled in the Evansville, Indiana area. The subjects did not take any antioxidant supplements or drugs other than the study products three months prior and during the study, and they consumed typical U.S. diets with less than 5 servings of fruits and vegetables. Twenty-five subjects received LifePak, and 25 received placebo for 6 weeks. After a six-week washout period, the treatments were reversed, so that each subject served as their own control. Blood samples were taken at the start and end of each treatment period and analyzed for serum antioxidants and LDL oxidizability. Four subjects dropped out, three of them for reasons not related to the study, and one due to mild adverse reactions to the placebo treatment.

The results showed that LifePak significantly improved antioxidant status as evidenced by increased serum concentrations of ascorbic acid (from 68.1 ± 24.8 to 94.3 ± 26.4 $\mu\text{mol/L}$, $p < 0.001$; means \pm SD, $n=46$) α -carotene

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(from 335 ± 197 to 716 ± 429 nmol/L; $p \leq 0.001$), α -carotene (from 77 ± 82 to 592 ± 364 nmol/L, $p \leq 0.001$), and vitamin E (α -tocopherol, from 20.0 ± 8.5 to 36.9 ± 13.0 μ mol/L, $p \leq 0.001$), with no changes in placebo treatment.

Most important, LifePak significantly decreased LDL (low-density lipoprotein) oxidizability, as the lag time was prolonged (by 17 %; $p \leq 0.001$), and oxidation rate was reduced ($p \leq 0.001$) without changes with placebo treatment. LDL oxidizability is believed to be an important factor in cardiovascular health, because oxidized LDL tend to adhere to the inner arterial wall more than non-oxidized LDL that are protected by antioxidants (2).

In summary, this study concluded that LifePak significantly increased antioxidant status, and decreased LDL oxidizability in healthy non-smokers consuming typical U.S. diets. Therefore, LifePak supplementation may have cardiovascular health benefits. Results also confirmed the assumption that a complex antioxidant nutrient combination can be efficacious in the presence of a full spectrum of non-antioxidant nutrients in a nutritionally complete vitamin/mineral/phytonutrient supplement.

A second LifePak clinical study, i.e., the 150-subject parallel design study, was conducted in the Houston, Texas area, and confirmed the results obtained from the crossover study in essentially all measurements. Antioxidant status was significantly improved and LDL oxidizability was reduced to very similar degree as in the Evansville, Indiana study. Thus, the antioxidant and cardiovascular benefits of LifePak are supported by two independent well-designed, double-blind clinical studies.

Health Benefits

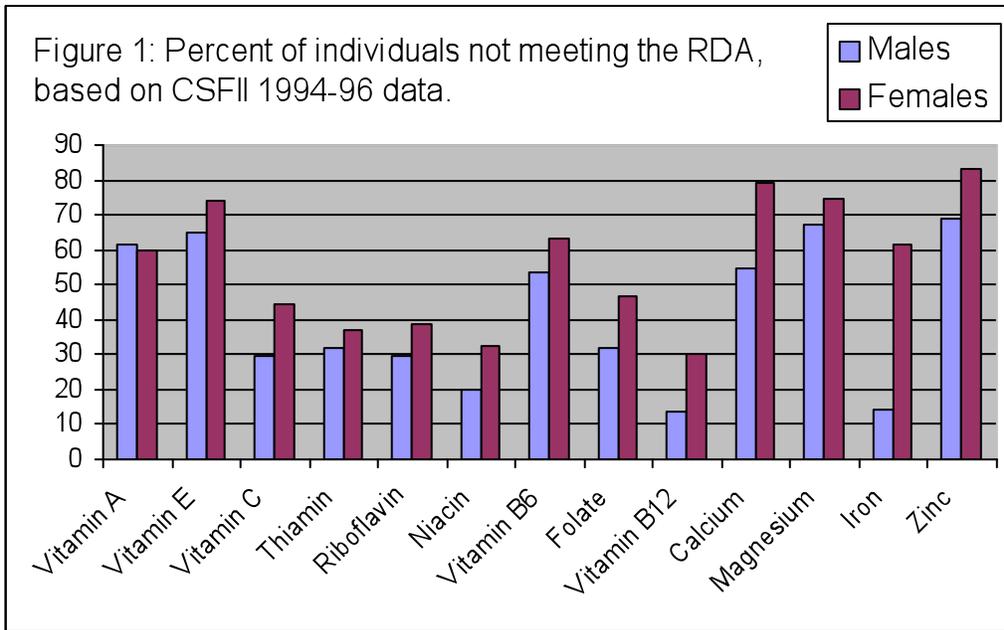
General Well-Being

LifePak is formulated as a convenient dietary supplementation program addressing general health and well-being for a healthy lifestyle. As a result, LifePak supplementation offers many more health benefits than ordinary multivitamins, and all of these health benefits are important in maintaining good general well-being for life. LifePak addresses the following important health issues: common nutrient deficiencies, anti-aging benefits, cardiovascular health, bone structure and function, insulin and blood glucose metabolism, immune function, and many others. The following paragraphs review these health benefits.

Avoiding Common Nutrient Deficiencies

Large nutrition surveys show consistently that inadequate intakes of essential vitamins and minerals are common in the U.S. and other industrialized countries (3-6). The Continuing Survey of Food Intakes by Individuals (CSFII) conducted by the US Department of Agriculture (USDA) in 1994-96 (3) showed that most people do not meet the Recommended Dietary Allowances (RDAs) for essential vitamins and minerals (See Figure 1). The most common nutrient deficiencies appear to be for the antioxidant vitamins A and E, vitamin B₆, the bone minerals calcium and magnesium, and the trace minerals iron—particularly for women—, and zinc (3). A large number of other studies document common nutrient deficiencies of vitamin D (7), thiamin (8-10), riboflavin (11-14), vitamin B₆ (15;16;16-22), folate (23-25), vitamin B₁₂ (15;26-37), calcium (5;38), magnesium (39-42), zinc (3;43-49), copper (50-56) and chromium (55;57-64).

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These common deficiencies in vitamin and mineral intakes can be attributed to the consumption of unbalanced diets that are low in fruits and vegetables (65;66) and rich in energy-dense, nutrient-poor foods (67). For example, an analysis by Block et al. of the National Health and Nutrition Examination Survey (NHANES II) data revealed that 41 % of the population had no fruit on the survey day, only one fourth had a fruit or vegetable rich in vitamin A or in vitamin C, and only ten percent consumed the recommended five servings of fruits and vegetables (68).

Aside from eating more balanced diets rich in fruits and vegetables, LifePak supplementation ensures meeting the RDAs for all vitamins and minerals. The amounts of vitamins and minerals included in LifePak were chosen not only to prevent vitamin and mineral deficiencies, but also to correct any pre-existing deficiencies with regular use.

Anti-Aging and Cell Protection Benefits

When discussing aging, it is important to separate age-associated diseases, e.g., heart disease, cancer, cataract, arthritis, Alzheimer’s disease, etc., from the aging process itself, although the severity of age-associated diseases may be affected by the progression of the aging process. Aging itself is the result of normal developmental and metabolic processes involving the progressive loss of function that eventually leads to the death of an organism (69). LifePak is designed to address the symptoms of the normal aging process, and provides protection to cellular and mitochondrial DNA, as well as to the lipids in cell membranes and the nervous system. The following paragraphs describe how special nutrients in LifePak contribute to these profound anti-aging benefits.

The most important factor in the aging process is maintaining the normal structure and function of the genetic code of every cell that is stored in the cell’s nucleus in the form of large nucleic acid molecules called DNA (deoxyribonucleic acid). DNA replicates and controls the inheritable characteristics of all organisms. Deficiencies of vitamin B₁₂, folic acid, vitamin B₆, niacin, vitamins C or E, or iron, or zinc can damage DNA by causing single- and double-strand breaks, oxidative lesions, or both (70;71). As described in the section above, most of these nutrient deficiencies are very common in our population, and are thought to be a major contributor to the aging process (70). According to Professor Bruce Ames of the University of California at Berkeley, “common micronutrient deficiencies are likely to damage DNA by the same mechanism as radiation and many chemicals, appear to be orders of magnitude more important, and should be compared for perspective. Remedying micronutrient deficiencies is likely to lead to a major improvement in health and an increase in longevity at low cost” (70;72).

Folic acid and vitamin B₁₂ are essential for normal DNA production and cell regeneration throughout the life cycle (72;72-78). Supplements of vitamin C can prevent DNA damage and promote DNA repair (79-81). Similar effects have been demonstrated in human and laboratory studies for other antioxidant nutrients provided by LifePak, such

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as lycopene (82-86), other carotenoids (87-89), vitamin E (81;90-92), alpha-lipoic acid (93), green tea catechins (94-97), quercetin (96;98-100), and soy isoflavones (100;101).

Duthie et al. tested the effects of combined antioxidant supplementation for 20 weeks with vitamin C (100 mg/day), vitamin E (280 mg/day), and beta-carotene (25 mg/day), and demonstrated a highly significant ($P < 0.002$) decrease in blood lymphocyte DNA damage in both smokers and nonsmokers (102). Other similar studies did not find significant reductions in DNA damage (103;104); however, this dichotomy of results can be explained by shortcomings in analytical methods, the types of biomarkers chosen, and problems in study design. Moreover, there are indications that phytonutrients from fruits and vegetables are more effective in protecting DNA than the antioxidant vitamins (89;103), and that antioxidant vitamins are more effective when combined with such phytonutrients (104), as in LifePak.

Mitochondria—the cell’s powerhouses—play a key role in cellular aging (70;71;105;106). Mitochondria are small structures inside cells that convert the energy from food nutrients into usable energy forms for cellular metabolism and functions (such as ATP and NADH). This mitochondrial energy conversion process—also known as respiration—requires plenty of oxygen, and generates free radicals as unwanted byproducts. As a result, mitochondria, and especially the mitochondrial DNA (their genetic material), are major targets of free radical attack (105-107). Unlike the cell’s nuclear DNA, mitochondrial DNA defects due to free radical damage are not always completely repaired, and accumulate more rapidly with advancing age (105-107). Levels of oxidative damage to mitochondrial DNA are several times higher than those of DNA in the cell’s nucleus (105;108). Experimental studies show that mitochondrial aging may be prevented or slowed down by improving antioxidant nutrient intake (70;105;108).

Alpha-lipoic acid is an antioxidant nutrient and mitochondrial enzyme cofactor that received particular attention in recent anti-aging research. Unlike other dietary antioxidants, alpha-lipoic acid has the unique ability to neutralize many different types of free radicals and to provide broad-spectrum support to the body’s antioxidant network (109;110). Alpha-lipoic acid also promotes the body’s production or regeneration of the two major intrinsic antioxidants, L-glutathione (111-113) and coenzyme Q₁₀ (109;114). Because of its universal antioxidant properties and involvement in mitochondrial protection, alpha-lipoic acid appears to be the most useful antioxidant supplement in addressing the oxidative stress and damage associated with the aging process (70;93;109;111).

Another important factor in normal aging is the prevention of lipid peroxidation, especially in the cell membranes, the brain and the vascular system. Vitamin E is perhaps the body’s most important fat-soluble antioxidant nutrient protecting healthy cells from oxidative free radical damage (115;116). Vitamin E is an especially valuable antioxidant in the lipid-rich cell membranes, where it prevents oxidation of unsaturated fatty acids by trapping free radicals (73;117). This helps stabilize and protect cell membranes (118), especially red blood cells and tissues sensitive to oxidation, such as the eyes (119) and the arteries (120-123). Many studies show that Vitamin E supplementation prevents lipid peroxidation of blood lipoproteins, such as the LDL and VLDL (122-125).

Alpha-lipoic acid appears to be an excellent antioxidant nutrient to help protect the highly polyunsaturated lipids in brain and nervous system tissues, as this effect has been demonstrated by numerous clinical and laboratory studies (126-132). The neuroprotective functions of alpha-lipoic acid have been ascribed to its unique ability to cross the blood-brain barrier (132).

The body’s proteins also become increasingly oxidized as we age (133). This is especially noticeable in the lens of the eye, where oxidized lens proteins can lead to senile cataract development and vision impairment. A number of human studies have shown that long-term supplementation with vitamins C and E can help protect eye lens and other proteins in the body from free radical damage associated with the normal aging process (134-138).

In summary, LifePak with its 30 mg alpha-lipoic acid, 500 mg vitamin C, 300 IU vitamin E, 600 mcg folic acid, 30 mcg vitamin B₁₂, 175 mg flavonoids, 15 mg mixed carotenoids and all other important micronutrients is optimally formulated to provide comprehensive protection of cellular and mitochondrial DNA, and the body’s lipids and proteins, which are key determinants of the aging process. As a result, long-term dietary supplementation with LifePak can be expected to provide significant anti-aging benefits.

Cardiovascular Health

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LifePak addresses many aspects of cardiovascular health. LifePak is formulated to provide the recommended amounts of the key cardiovascular nutrients, such as vitamin E, vitamin C, carotenoids, flavonoids, vitamin B₆, folate, vitamin B₁₂, magnesium and calcium. The clinical effects of LifePak supplementation on LDL oxidation—a key factor for cardiovascular health—have been reviewed in the Scientific Studies section above.

Thousands of scientific studies document the beneficial effects of individual antioxidant nutrients on cardiovascular health (139), and a number of studies indicated that combinations of antioxidant vitamins, carotenoids and flavonoids are believed to be more effective than supplementation with any of these nutrients alone (1;140-142). LifePak is such a combination. The nutrients provided by LifePak have been shown to promote healthy vascular function, and to support normal blood pressure, heart function and microcirculation. The following paragraphs show which nutrients in LifePak contribute to these cardiovascular benefits.

Vitamin E has been intensively studied, and most experts agree that daily dietary supplementation with 100 to 400 IU vitamin E has long-term cardiovascular benefits (143-145). Chan provided an excellent review of the mechanisms by which vitamin E exerts its protective effects (146). One such mechanism is improving the resistance of LDL against free-radical-induced oxidation (2). Numerous clinical studies demonstrated that vitamin E inhibits LDL oxidation (122;147;148). Likewise, the study by Smidt et al. showed that LifePak significantly decreased LDL oxidation, and this decrease was correlated to the response of vitamin E blood serum levels (1). Vitamin E exerts its cardiovascular benefits also through other mechanisms, including the regulation of adhesion of blood platelets, monocytes and T lymphocytes to the vascular endothelium, affecting endothelial fatty acid (eicosanoid) metabolism, smooth muscle cell proliferation and platelet function (146;149). Recent clinical studies provided evidence that vitamin E supplements can help promote normal arterial wall function and thickness (150-152).

LifePak provides vitamin E derived entirely from natural sources. The natural *d*- α -tocopheryl acetate and *d*- α -tocopherol used in LifePak are about twice as bioavailable as the synthetic *dl*- α -tocopherol used in other leading brand multivitamins (153-156). In addition to *d*- α -tocopherol, LifePak also provides mixed natural tocopherols and tocotrienols. The level of 300 IU of vitamin E in LifePak is many times above the RDA (22 IU) or Daily Value (30 IU), and is supported by numerous human supplementation studies that show significant health benefits at daily vitamin E intakes between 100 and 400 IU (139;143-145;157).

Vitamin C (ascorbic acid) is another antioxidant nutrient with cardiovascular benefits at above-RDA amounts (158-160). This is supported by research that shows that vitamin C interacts and regenerates vitamin E in the body (161;162), and by clinical studies that demonstrate that vitamin C supplements can inhibit LDL oxidation (125;163), promote normal blood pressure (164-168), blood lipids (165;169), coronary microcirculation (170) and vascular endothelial function (171-177). In addition, numerous epidemiological studies show strong associations between cardiovascular health and vitamin C intakes or blood serum levels (160;178;179;180;180-182).

Most human vitamin C supplementation studies used 100 to 1,000 mg per day, and pharmacokinetic studies by Levine et al. show that in healthy people blood serum concentrations plateau at dietary intakes above 200 mg per day (183;184). Based on these studies, LifePak provides 500 mg vitamin C in the form of calcium ascorbate, a well-tolerated, non-acidic form of vitamin C.

Carotenoids are a class of phytonutrients with many important nutritional and biochemical functions in mammals. Carotenoid intakes in the U.S. population are considered low, and reflect low fruit and vegetable consumption (185). Epidemiological studies suggest that high carotenoid intakes from fruits and vegetables protect against cardiovascular disease and cancer (186-188). However, the Physicians Health Study showed that 50 mg synthetic (all-*trans*) β -carotene taken every other day for 12 years produced no cardiovascular health benefits (189). Current scientific evidence suggests that combinations of several carotenoids rather than mega-doses of synthetic β -carotene may exert the expected protective effects (86;186;187;190). Carotenoids other than β -carotene appear to have profound cardiovascular health benefits (191;192). Lycopene helps protect LDL from oxidation (193;194), and β -carotene (195;196) and lutein (197;198) may be protective as well.

LifePak provides a balanced carotenoid combination in amounts similar to those provided by diets high in fruits and vegetables: 6 mg β -carotene, 5 mg lycopene, 2 mg β -carotene and 2 mg lutein.

Flavonoids form an important class of antioxidant phytonutrients with cardiovascular health benefits (199). It is estimated that there are over 600 different flavonoids present in foods and beverages. Large epidemiological studies suggest that dietary flavonoid intake from fruits, vegetables, tea, grape juice and red wine is positively associated

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with cardiovascular health (200-205). Green tea catechins have been shown to decrease LDL oxidizability and total cholesterol (206-210). Grape seed proanthocyanidins may support the resistance of LDL against oxidation (211). Soy isoflavones may promote normal blood lipids, vascular function and LDL resistance to oxidation (212-219). Some research also supports that different flavonoids may have synergistic effects when combined (220).

Estimates of average daily flavonoid consumption in industrialized nations vary from 20 to 100 mg per day (221-223). LifePak provides an additional 175 mg of flavonoids from five standardized botanical extracts that all have been extensively researched: 90 mg green tea catechins, 25 mg quercetin, 25 mg citrus bioflavonoids (hesperidin, naringenin), 25 mg grape seed proanthocyanidins and polyphenols, and 10 mg soy isoflavones (genistein, diadzein).

The B-vitamins B₆, B₁₂ and folic acid are necessary to maintain normal, low blood levels of homocysteine. Homocysteine is an amino acid derived from methionine metabolism that can adversely affect lipid deposition and inflammation of the vascular wall (224;225). Many studies have established homocysteine as an independent risk factor for cardiovascular disease (226-230). Current estimates are that about 10-15 % of individuals are genetically predisposed to have high blood homocysteine (231). Independently of its role in homocysteine metabolism, vitamin B₆ appears to have other benefits for cardiovascular health as well (232).

Supplementation studies showed that primarily folic acid, but also vitamins B₆ and B₁₂, promote normal, low homocysteine levels (233). Initially, pharmacological doses of folic acid, e.g., 1-5 mg/day, were used to lower homocysteine serum levels (234). However, recent studies showed that as little as 200 µg/day folic acid is effective (233;235-237). LifePak provides 600 µg/day folic acid, 10 mg/day vitamin B₆ and 30 µg/day vitamin B₁₂; these levels are well within clinically effective doses to promote normal homocysteine levels.

Magnesium deficiency is very common and characterized by cardiovascular symptoms (73;238). Magnesium influences many mechanical, electrical and structural functions of cardiac and vascular cells, and small changes in blood or cellular magnesium levels may have significant effects on cardiac excitability and on vascular tone, contractility and reactivity. This explains why magnesium is important in the physiological regulation of blood pressure (239). A number of clinical studies support that supplemental magnesium can help promote normal blood pressure (239-243), while some studies showed no effect (244;245). Magnesium may also be important in regulating thrombosis (246) and heart rhythm (247;248).

Calcium deficiency is a widespread problem with cardiovascular health implications. Adequate dietary calcium intake appears to be an important factor in promoting normal blood pressure (249;250), and this relationship has been sufficiently confirmed by clinical studies (251-253) and a recent meta-analysis of clinical calcium supplementation trials (254).

The generous amounts of calcium (500 mg/day) and magnesium (250 mg/day) in LifePak ensure meeting the RDAs in conjunction with typical U.S. diets that are often low in these two minerals (3;38;255).

Bone Nutrition

LifePak addresses bone health with a comprehensive array of bone nutrients, all present in nutritionally significant amounts: calcium, magnesium, vitamin D, vitamin K, boron, silicon and soy isoflavones (phytoestrogens).

Undoubtedly, calcium has received the most attention as a bone nutrient (256). Calcium is the major bone mineral and structural component in the form of calcium hydroxyapatite. Calcium supplementation can increase bone mineralization in children and young adults (257-260), prevent bone loss in the elderly (261;262), and reduce the risk for osteoporosis (260;263-265). In fact, the FDA has approved the health claim for food and dietary supplements that adequate intakes of calcium, especially earlier in life, can slow the progression of osteoporosis later in life. Recently, the Food and Nutrition Board of the National Research Council announced new Adequate Intake (AI) values for calcium of 1,000 to 1,200 mg/day for adults (266). Data from the USDA 1987-88 Nationwide Food Consumption Survey showed that mean per capita daily consumption of calcium for the total U.S. population was only 737 mg (38). LifePak provides an additional 500 mg of calcium, which is the right supplemental amount to ensure that most individuals meet their dietary calcium requirements. Most other multivitamins supply considerably less calcium than LifePak.

As the second most abundant bone mineral, magnesium appears to be equally important for bone health as calcium (267;268), especially as marginal or inadequate magnesium intake is a significant concern in the U.S. (255). The

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1996 USDA Continuing Survey of Food Intakes by Individuals (CSFII) showed that approximately three out of four adult women and two out of three adult men do not meet the RDA for magnesium (3). Magnesium is involved in the regulation of calcium transport and metabolism (269), and as such assumes a key role in bone formation (267;270). Magnesium deficiency has been shown to result in low bone mineral density (267;269;271;272). LifePak provides 250 mg of magnesium to ensure that the new RDAs of 320 mg/day for women and 420 mg/day for men (266) can be met easily.

The role of vitamin D in calcium and bone metabolism is well established (273-275). There are a number of clinical trials documenting the benefits of supplemental vitamin D for maintaining normal bone health and calcium metabolism, especially in the elderly (276-279). Although vitamin D is produced in the skin upon sunlight exposure, marginal vitamin D status is common especially in the elderly living in the northern latitudes of the U.S. and Canada (274;280-282). As a result, Holick recommended vitamin D supplementation from multivitamins in the amount of 400 IU daily (282). LifePak provides 400 IU of vitamin D per day.

LifePak provides four other bone nutrients that are not typically found in other multivitamin/mineral supplements: vitamin K, boron, silicon and soy isoflavones. Historically known for its role in blood coagulation, vitamin K is required for the formation of several calcium-binding proteins that are involved in bone formation, most notably osteocalcin (283-288). It is now believed that adequate vitamin K nutrition is necessary to maintain bone health throughout life (287;288). Boron is thought to affect bone health by its involvement in steroid hormone metabolism (271;289). Among other factors, boron appears to be necessary for calcium and magnesium absorption, their adequate renal reabsorption, and their incorporation into the bone matrix (73;271;289-300). Laboratory studies showed that silicon deprivation results in abnormal bone formation and skeletal malformations (301-303), and reduces the incorporation of calcium and magnesium into bone (304;305). Silicon affects cartilage composition and cartilage calcification, the early steps in bone formation (292;301;303). Experimental studies showed that silicon supplementation is able to promote bone formation as well as inhibit bone resorption (306). The soy isoflavones genistein and daidzein support bone health by virtue of their roles as phytoestrogens (307). Studies show that soy isoflavones appear to promote bone mineralization and may reduce bone resorption (216;308).

LifePak provides 40 µg vitamin K₁ (50 % of RDI), 3 mg each of boron and silicon, and 10 mg of soy isoflavones, equivalent to approximately 10 grams of soy protein. Together with the significant amounts of calcium, magnesium and vitamin D, LifePak provides an exceptionally comprehensive approach in promoting healthy bone structure.

Insulin and Blood Glucose Metabolism

LifePak provides nutritionally meaningful amounts of vitamins and minerals that promote normal glucose metabolism and insulin function. Although LifePak is a dietary supplement and not designed to treat or prevent diseases, its high levels of antioxidant vitamins C and E, and the presence of significant amounts of alpha-lipoic acid, magnesium, zinc and chromium, make LifePak an appropriate dietary supplement for people with insulin resistance, impaired fasting glucose, type 1 or type 2 diabetes mellitus, or metabolic syndrome X.

Chromium is essential for normal insulin function (73;309-311). Clinical observations showed that the impaired glucose tolerance seen in patients receiving chromium deficient total parenteral nutrition could be reversed by supplemental chromium (73;312-315). It is now generally accepted that chromium acts as a cofactor for insulin (73;309;310). The reported mechanism of action of chromium involves increased insulin binding, increased insulin receptor number, and increased insulin receptor sensitivity (310). Chromium supplementation has been shown to promote healthy blood glucose metabolism without any documented side effects in people with mild glucose intolerance to overt type 2 diabetics (310;316). Many clinical studies show that chromium supplementation lowers blood insulin levels (317), improves glucose tolerance (317) and decreases hemoglobin glycosylation (317) in people with type 2 diabetes. It is believed that the positive effects of chromium supplementation are simply the results of correcting existing chromium deficiency, and do not involve pharmacological actions (318;319). Inadequate chromium nutrition appears to be widespread in the U.S. and other industrialized countries {14597, 17645}, and may affect as much as 90% of the U.S. population (58). Most chromium supplementation studies in humans have used 200 µg of chromium daily (309;310), which is the same amount as provided by LifePak. The form of chromium in LifePak is a glycine-niacin-chelate (Albion Laboratories).

Zinc deficiency is also very common in people with diabetes (320-322), and is attributed largely to poor dietary intake and high urinary excretion (323). Zinc may also promote normal insulin function by a more direct mechanism

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(320;324). Frequently, diabetic subjects are also at increased risk of magnesium deficiency (325), which is due to low dietary intake and excessive urinary magnesium excretion (326;326-328). LifePak provides 15 mg zinc and 250 mg magnesium.

Antioxidant status is often low in patients with diabetes (329;330), and supplementation with antioxidant nutrients has resulted in significant nutritional benefits (331). Such antioxidant nutrients do not treat or prevent diabetes, but address special nutritional requirements. For example, in many studies people with diabetes benefited from dietary supplementation with vitamin E, because it promoted normal platelet function (332;333), and provided antioxidant protection of the nervous system (334) and the body's proteins and hemoglobin (332;335-338). As a result, daily vitamin E supplementation has been recommended as part of a healthy diabetes diet (331;339). Diabetic subjects often have low serum vitamin C levels (340-344), and vitamin C transport into the cell is impaired as well due to high sorbitol levels (345). Sorbitol is a sugar-alcohol that accumulates inside the cells of diabetic people. Supplemental vitamin C is known to promote normal sorbitol metabolism (331;346-349) and may also help maintain normal blood lipid levels (350) in diabetic subjects. LifePak provides clinically meaningful amounts of vitamin E (300 IU/day) and vitamin C (500 mg/day).

Alpha-lipoic acid supplementation of people with diabetes has been shown to significantly promote antioxidant protection and vitamin E status (128;351). Alpha-lipoic acid has the ability to cross the blood-brain barrier, so that it can exert its antioxidant benefits in the central and peripheral nervous system (129;132;352). Numerous clinical studies document the ability of pharmacological doses of alpha-lipoic acid (600 mg/day) to promote normal peripheral nerve function in people with diabetes (131;353;354). LifePak is not designed to treat diabetic neuropathy, and provides 30 mg alpha-lipoic acid, an amount considered appropriate for maintaining general antioxidant support in the nervous system (Lester Packer, Ph.D., personal communication).

Immune Function

Since the immune system depends on adequate nutritional status of many vitamins and minerals, it is expected that LifePak effectively promotes healthy immune function in many ways.

Deficiency of single nutrients results in altered immune responses, and this is observed even when the deficiency state is relatively mild. Vitamins A, C, E, and B₆, zinc and selenium all have important influences on the immune system (355;356), and supplementation with these nutrients has been shown to improve immunity of populations at risk of deficiencies (357;358). The following paragraphs describe how each of these nutrients helps promote normal immune function.

Vitamin A is essential for maintaining a normal immune response (73;359). There appears to be a vicious cycle: during vitamin A deficiency, immune function is impaired (359) which puts the body at increased risk for infections (360). Acute infections further deplete the body of vitamin A (361). Beta-carotene may also promote normal immune function independently of its provitamin A functions (362-365).

Numerous studies support that vitamin C supplementation can promote the normal immune response to occasional infections (366-371). There is some evidence that during a cold infection vitamin C tissue requirements may be temporarily increased (372).

Several clinical studies have confirmed the immune benefits of vitamin E in amounts of 100 to 400 IU per day (366;373;374). Meydani et al. have conducted a study to determine whether long-term (235 days) supplementation with 60, 200 and 800 mg vitamin E enhances clinically relevant measures of cell-mediated immunity in 88 healthy elderly subjects (375). Subjects consuming 200 mg/day of vitamin E had a 65% increase in delayed-type hypersensitivity skin response and a 6-fold increase in antibody titer to a hepatitis B vaccine compared with placebo (17% and 3-fold, respectively). The 200 mg/day group also had a significant increase in antibody titer to tetanus vaccine. Overall, results indicated that above-RDA vitamin E enhances clinically relevant indexes of T-cell-mediated function in healthy elderly persons (375). LifePak provides 300 IU/day of natural *d*- α -tocopherol, equivalent to 201 mg.

Population studies showed that vitamin B₆ nutrition is associated with immune function (376;377). These findings were confirmed by human intervention studies which demonstrated that supplementation of elderly subjects with RDA-amounts of vitamin B₆ (2-3 mg/day) was able to restore normal immune function (357;378). Other studies showed similar immune benefits of vitamin B₆ at higher levels (379;380).

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Zinc is known to play a central role in the immune system, and zinc-deficient people experience increased susceptibility to a variety of pathogens (47;381-388). Zinc also is important for normal wound healing (389). Zinc affects multiple aspects of the immune system, from the barrier of the skin to gene regulation within lymphocytes. Zinc is crucial for normal development and function of cells mediating nonspecific immunity such as neutrophils and natural killer cells. The effects of zinc on these key immunologic functions is rooted in the myriad roles for zinc in basic cellular functions such as DNA replication, RNA transcription, cell division, and cell activation (386).

Adequate selenium status appears to be necessary for normal immune function (390-392). This may be due to selenium's functions as the cofactor for glutathione peroxidase (390), or to more specific functions of selenium on cellular immunity (392;393). Good selenium nutrition also appears to be a requirement for normal anti-viral defense (394-396).

Finally, there are studies that substantiate the clinical benefits of vitamin/mineral combinations on immune function. For example, Girodon et al. studied the effects of a combined supplement of 20 mg zinc, 100 mcg selenium, 120 mg vitamin C, 6 mg beta-carotene and 15 mg vitamin E in a study of 81 elderly people for two years, and found that the supplemented group had significantly fewer infections during the study (397).

Other Health Benefits

LifePak can help prevent neural tube defects, because it provides folic acid. Daily supplements of 400 µg folic acid have been widely recommended to women of childbearing age to prevent primary and secondary neural tube defects (398-401). LifePak provides 600 µg folic acid per day.

LifePak is also an excellent supplement to help promote normal eye function, because it provides clinically meaningful amounts of nutrients that have been shown to protect ocular function as we age. These nutrients include lutein (134;138;402-409), vitamin C (134;138;410;411) and vitamin E (136-138;409;410;412-415).

With its 39 vitamins, minerals and phytonutrients, LifePak has many more health benefits than the ones outlined here—too many to be discussed within the format of this monograph.

Side Effects

There are no known side effects of LifePak or any of its ingredients at the recommended usage levels. Likewise, a clinical study of LifePak in 46 healthy subjects conducted under FDA Good Clinical Practices guidelines revealed no adverse effects attributable to LifePak (1). Similar observations were made in another, similar clinical study of LifePak in 140 healthy subjects (unpublished results).

Safety and Toxicology Data

Each ingredient in LifePak is present in amounts that are documented to be safe for long-term supplementation. The daily amounts of all vitamins and minerals are well below the No-Observed Adverse Effect Levels (NOAEL) established by the Council for Responsible Nutrition (CRN) in 1997 (416) and the Upper Limits (UL) established by the Food and Nutrition Board of the National Research Council (266;417;418). The other nutrients of LifePak, i.e., the phytonutrients, are added in amounts that can be obtained from diets high in fruits and vegetables (5-10 servings/day) or other commonly consumed foods and beverages. All of the phytonutrient extracts used in LifePak are documented to be safe and non-toxic. These extracts have been studied in humans at daily intakes similar or higher than those supplied by LifePak, and no significant side effects were reported.

Drug Interactions

Many drugs can alter the metabolism and bioavailability of vitamins and minerals, and likewise—although much less frequently—some nutrients may also affect drug pharmacokinetics (419;420). For example, antituberculous drugs

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such as INH and cycloserine interfere with vitamin B₆ metabolism and may also produce a secondary niacin deficiency. Oral contraceptives interfere with the metabolism of folic acid, ascorbic acid and riboflavin. Anticonvulsants can act as folate antagonists and precipitate folic acid deficiency, and supplementation with folate has been recommended along with anticonvulsant therapy. Cholestyramine therapy has been associated with malabsorption of vitamins, such as vitamins K and D, and folic acid. Multivitamin supplementation has been recommended to avoid such adverse effects of drugs on nutrient metabolism. An excellent recent review of drug-nutrient interactions was prepared by Thomas (419).

One of the more frequent concerns among physicians is the potential interaction between vitamin K and anticoagulant drugs, such as warfarin and coumarin. However, significant reductions in efficacy of anticoagulant drugs require high-dose vitamin K supplementation of 250 µg per day or more (421;422). Anticoagulant therapy may also be affected by the daily variability in vitamin K intake from food rich in vitamin K, such as green leafy vegetables and broccoli which may contain up to 400 µg vitamin K per serving. As a result, diets with constant rather than low vitamin K content have been recommended for patients on anticoagulant therapy (423;424). LifePak provides 40 µg (50 % RDI) daily of vitamin K, a level that has never been documented to interfere with anticoagulant therapy.

Proprietary Processing

The combination of quality ingredients, qualified manufacturers, certified independent laboratory verification, and a continuous drive to supply leading edge products, ensure our representatives and consumers the highest quality products available in the industry. LifePak is guaranteed to contain no added sugar, salt, wheat, dairy products, artificial preservatives, colors or flavors.

The vitamins and minerals used in Pharmanex products meet the requirements and guidelines established by the United States Pharmacopoeia (USP) and/or Food Chemicals Codex (FCC) where applicable. Every batch of LifePak meets the USP XXIV requirements for capsule disintegration. All ingredients are tested for purity, and where applicable, ingredients are certified pure by microbial testing, such as tests for Salmonella, E. coli, other coliforms, Staphylococcus aureus, total plate counts, yeasts, molds and pesticide residues. Our manufacturers go through a detailed selection and certification process to assure their compliance with Good Manufacturing Practice (GMP) standards set by the Food and Drug Administration (FDA).

Directions for Use

Take the contents of one LifePak packet with eight ounces of liquid with your morning and evening meals.

How Supplied

Each box provides 60 individual packets, or the equivalent of a one-month supply. Each packet contains one vitamin capsule, one phytonutrient capsule and two mineral capsules.

Storage

Store in a cool, dry place, away from direct sunlight. Keep out of reach of children.

Shelf Life

LifePak is formulated to be stable at room temperature for at least two years from the date of manufacture.

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Warnings

Keep this product out of reach of children. Accidental overdose of iron containing products is a leading cause of fatal poisoning in children under six years of age. In case of accidental overdose, call a doctor or poison control center immediately.

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Formula

The nutrient composition and ingredient sources of LifePak[®] are listed below. LifePak is provided in two daily packets, each containing one vitamin capsule, one phytonutrient capsule and two mineral capsules.

Eight capsules (= 1 daily supply in 2 packets) provide:	Amount	% DV¹
Vitamin A (retinyl palmitate)	2,5000	IU 100
β-Carotene (from Palm fruit extract, <i>Blakeslea trispora</i>), 6 mg	12,500	IU 200
Vitamin C (calcium ascorbate)	500	mg 833
Vitamin D ₃ (cholecalciferol).....	400	IU 100
Vitamin E (d-α-tocopheryl acetate, mixed tocopherols, and tocotrienols).....	300	IU 1,000
Thiamin (mononitrate).....	7.5	mg 500
Riboflavin	8.5	mg 500
Niacin (niacin, niacinamide).....	40	mg 200
Vitamin B ₆ (pyridoxine hydrochloride).....	10	mg 500
Folate (folic acid).....	600	μg 150
Vitamin B ₁₂ (cyanocobalamin)	30	μg 500
Biotin	300	μg 100
Pantothenic Acid (D-calcium pantothenate).....	30	mg 200
Inositol	10	mg n/a
Vitamin K ₁ (phylloquinone)	40	μg 50
Calcium (propionate, carbonate, ascorbate)	500	mg 50
Magnesium (amino acid chelate, oxide).....	250	mg 63
Iodine (potassium iodide)	100	μg 67
Zinc (amino acid chelate)	15	mg 100
Copper (amino acid chelate).....	1	mg 100
Manganese (amino acid chelate)	2	mg 200
Selenium (L-selenomethionine, sodium selenite).....	140	μg 200
Chromium (amino acid chelate)	200	μg 167
Molybdenum (amino acid chelate)	75	μg 100
Vanadium (vanadyl sulfate).....	20	μg n/a
Silicon (sodium metasilicate)	3	mg n/a
Boron (citrate).....	3	mg n/a
α-Lipoic Acid	30	mg n/a
Carotenoid Blend (other than β-carotene):		
Lutein (from marigold flower extract).....	2	mg n/a
Lycopene	5	mg n/a
β-Carotene (from palm fruit extract).....	2	mg n/a
Flavonoid Blend:		
Catechins (from <i>Camellia sinensis</i> extract).....	90	mg n/a
Grape Seed Extract (min. 92% polyphenols)	25	mg n/a
Quercetin	25	mg n/a
Citrus Bioflavonoids (hesperidin, naringenin)	25	mg n/a
Soy Isoflavones (from soy isoflavone extract, 40%).....	5	mg n/a

¹U.S. Food and Drug Administration, Daily Values for nutrition labeling.

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References

1. Smidt CR, Seidehamel RJ, Devaraj S, Jialal I. The effects of a nutritionally complete dietary supplement (LifePak) on antioxidant status and LDL-oxidation in healthy non-smokers. *FASEB J* 1999;13:A546.
2. Holvoet P, Collen D. Oxidized lipoproteins in atherosclerosis and thrombosis. *FASEB J*. 1994;8:1279-84.
3. U.S.Department of Agriculture, Agricultural Research Service. Data Tables: Results from USDA's 1996 Continuing Survey of Food Intakes by Individuals and 1996 Diet and Health Knowledge Survey. ARS Food Surveys Research Group 97. Electronic Citation.
4. Block G, Abrams B. Vitamin and mineral status of women of childbearing potential. *Ann.N.Y.Acad.Sci.* 1993;678:244-54.
5. Pennington JAT. Intakes of minerals from diets and foods: Is there a need for concern? *J.Nutr.* 1996;126:2304S-8S.
6. Benton D, Haller J, Fordy J. The vitamin status of young British adults. *Int J Vitam.Nutr Res* 1997;67:34-40.
7. Delvin EE, Imbach A, Copti M. Vitamin D nutritional status and related biochemical indices in an autonomous elderly population. *Am.J.Clin.Nutr.* 1988;48:373-8.
8. Nichols HK, Basu TK. Thiamin status of the elderly: dietary intake and thiamin pyrophosphate response. *J.Am.Coll.Nutr.* 1994;13:57-61.
9. Skelton WP, III, Skelton NK. Thiamine deficiency neuropathy. It's still common today. *Postgrad.Med.* 1989;85:301-6.
10. Smidt LJ, Cremin FM, Grivetti LE, Clifford AJ. Influence of thiamin supplementation on the health and general well-being of an elderly Irish population with marginal thiamin deficiency. *J.Gerontol.* 1991;46:M16-22.
11. Tiidus P, Shephard RJ, Montelpare W. Overall intake of energy and key nutrients: data for middle-aged and older middle-class adults. *Can.J.Sport.Sci.* 1989;14:173-7.
12. Gonzalez-Gross M, Ortega RM, Andres P, Varela G. Riboflavin status in a group of institutionalized elderly. *Int.J.Vitam.Nutr.Res.* 1991;61:120-4.
13. Toh SY, Thompson GW, Basu TK. Riboflavin status of the elderly: dietary intake and FAD-stimulating effect on erythrocyte glutathione reductase coefficients. *Eur J Clin Nutr* 1994;48:654-9.
14. van der Wielen RP, de Wild GM, de Groot LC, Hoefnagels WH, van Staveren WA. Dietary intakes of energy and water-soluble vitamins in different categories of aging. *J Gerontol A Biol Sci Med Sci* 1996;51:B100-B107.
15. Haller J, Lowik MR, Ferry M, Ferro-Luzzi A. Nutritional status: blood vitamins A, E, B6, B12, folic acid and carotene. Euronut SENECA investigators. *Eur.J.Clin.Nutr.* 1991;45 Suppl 3:63-82.
16. Albertson AM, Tobelmann RC, Engstrom A, Asp EH. Nutrient intakes of 2- to 10-year-old American children: 10-year trends. *J.Am.Diet.Assoc.* 1992;92:1492-6.
17. Manore MM, Vaughan LA, Carroll SS, Leklem JE. Plasma pyridoxal 5'-phosphate concentration and dietary vitamin B-6 intake in free-living, low-income elderly people. *Am.J.Clin.Nutr.* 1989;50:339-45.
18. George JH, Brinsdon SC, Paulin JM, Aitken EF. What do young adolescent New Zealanders eat? Nutrient intakes of a nationwide sample of form 1 children. *N Z Med J* 1993;106:47-51.
19. Driskell JA, Clark AJ, Bazzarre TL et al. Vitamin B-6 status of southern adolescent girls. *J Am Diet Assoc* 1985;85:46-9.
20. Guillard JC, Penaranda T, Gallet C, Boggio V, Fuchs F, Klepping J. Vitamin status of young athletes including the effects of supplementation. *Med.Sci.Sports Exerc.* 1989;21:441-9.
21. van der Beek EJ, Lowik MR, Hulshof KF, Kistemaker C. Combinations of low thiamin, riboflavin, vitamin B6 and vitamin C intake among Dutch adults. (Dutch Nutrition Surveillance System). *J.Am.Coll.Nutr.* 1994;13:383-91.
22. Kant, A. K. and Block, G. Dietary vitamin B-6 intake and food sources in the US population: NHANES II, 1976-1980. *Am.J.Clin.Nutr.* 52(4), 707-716. 1990.
23. Sauberlich HE. Folate status of U.S. population groups. In: Bailey LB, ed. *Folate in Health and Disease*. New York: Marcel Dekker, Inc. 1995:171-95.
24. Lewis CJ, Crane NT, Wilson DB, Yetley EA. Estimated folate intakes: data updated to reflect food fortification, increased bioavailability, and dietary supplement use. *Am.J.Clin.Nutr.* 1999;70:198-207.
25. Quinn K, Basu TK. Folate and vitamin B12 status of the elderly. *Eur.J Clin Nutr* 1996;50:340-2.
26. Joosten E, van den Berg A, Riezler R et al. Metabolic evidence that deficiencies of vitamin B-12 (cobalamin), folate, and vitamin B-6 occur commonly in elderly people. *Am.J.Clin.Nutr.* 1993;58:468-76.
27. Carmel R. Current concepts in cobalamin deficiency. *Annu.Rev.Med.* 2000;51:357-75.
28. Lindenbaum J, Rosenberg IH, Wilson PW, Stabler SP, Allen RH. Prevalence of cobalamin deficiency in the Framingham elderly population. *Am.J.Clin.Nutr.* 1994;60:2-11.
29. Selhub J, Jacques PF, Wilson PW, Rush D, Rosenberg IH. Vitamin status and intake as primary determinants of homocysteinemia in an elderly population. *JAMA* 1993;270:2693-8.
30. Stabler SP, Lindenbaum J, Allen RH. Vitamin B-12 deficiency in the elderly: current dilemmas. *Am.J.Clin.Nutr.* 1997;66:741-9.
31. Baik HW, Russell RM. Vitamin B₁₂ deficiency in the elderly. *Annu.Rev.Nutr.* 1999;19:357-77.
32. Gadowsky SL, Gale K, Wolfe SA, Jory J, Gibson R, O'Connor DL. Biochemical folate, B12, and iron status of a group of pregnant adolescents accessed through the public health system in southern Ontario. *J.Adolesc.Health* 1995;16:465-74.
33. Saltzman JR, Kemp JA, Golner BB, Pedrosa MC, Dallal GE, Russell RM. Effect of hypochlorhydria due to omeprazole treatment or atrophic gastritis on protein-bound vitamin B₁₂ absorption. *J.Am.Coll.Nutr.* 1994;13:584-91.

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34. Lowik MR, Schrijver J, Odink J, van den Berg H, Wedel M. Long-term effects of a vegetarian diet on the nutritional status of elderly people (Dutch Nutrition Surveillance System). *J.Am.Coll.Nutr.* 1990;9:600-9.
35. Millet P, Guillard JC, Fuchs F, Klepping J. Nutrient intake and vitamin status of healthy French vegetarians and nonvegetarians. *Am.J.Clin.Nutr.* 1989;50:718-27.
36. Janelle KC, Barr SI. Nutrient intakes and eating behavior scores of vegetarian and nonvegetarian women. *J Am Diet.Assoc* 1995;95:180-6, 189, quiz.
37. Clementz GL, Schade SG. The spectrum of vitamin B12 deficiency. *Am Fam.Physician* 1990;41:150-62.
38. Fleming KH, Heimbach JT. Consumption of calcium in the U.S.: Food sources and intake levels. *J.Nutr.* 1994;124 Suppl.:1426S-30S.
39. Costello RB, Moser-Veillon PB. A review of magnesium intake in the elderly. A cause for concern? *Magnes.Res.* 1992;5:61-7.
40. Lichten IJ. Dietary intake levels and requirements of Mg and Ca for different segments of the U.S. population. *Magnesium* 1989;8:117-23.
41. Durlach J, Durlach V, Bac P, Rayssiguier Y, Bara M, Guet-Bara A. Magnesium and ageing. II. Clinical data: Aetiological mechanisms and pathophysiological consequences of magnesium deficit in the elderly. *Magnes.Res.* 1993;6:379-94.
42. Gullestad L, Nes M, Ronneberg R, Midtvedt K, Falch D, Kjekshus J. Magnesium status in healthy free-living elderly Norwegians. *J.Am.Coll.Nutr.* 1994;13:45-50.
43. Prasad AS. Zinc: an overview. *Nutrition.* 1995;11:93-9.
44. Roebothan BV, Chandra RK. Nutrient consumption and body size in a group of institutionalized elderly. *Nutr.Res.* 1994;14:35-9.
45. Mares-Perlman JA, Subar AF, Block G, Greger JL, Luby MH. Zinc intake and sources in the US adult population: 1976-1980. *J.Am.Coll.Nutr.* 1995;14:349-57.
46. Small SP, Best DG, Hustins KA. Energy and nutrient intakes of independently-living, elderly women. *Can.J.Nurs.Res.* 1994;26:71-81.
47. Prasad AS, Fitzgerald JT, Hess JW, Kaplan J, Pelen F, Dardenne M. Zinc deficiency in elderly patients. *Nutrition.* 1993;9:218-24.
48. Sandstead HH. Is zinc deficiency a public health problem? *Nutrition.* 1995;11:87-92.
49. Hambidge M. Human zinc deficiency. *J.Nutr.* 2000;130:1344S-9S.
50. Pennington JAT, Young BE, Wilson DB. Nutritional elements in U.S. diets: Results from the total diet study, 1982-86. *J.Am.Diet.Assoc.* 1989;89:659-64.
51. Klevay LM. Cardiovascular disease from copper deficiency - A history. *J.Nutr.* 2000;130:489S-92S.
52. Uauy R, Olivares M, Gonzalez M. Essentiality of copper in humans. *Am.J.Clin.Nutr.* 1998;67:952S-9S.
53. Abdulla, M., Behbehani, A., and Dashti, H. Dietary intake and bioavailability of trace elements. *Biol.Trace Elem.Res.* 21, 173-178. 1989.
54. Baghurst KI, Record SJ. The vitamin and mineral intake of a free-living young elderly Australian population in relation to total diet and supplementation practices. *Hum.Nutr Appl.Nutr* 1987;41:327-37.
55. Anderson RA, Bryden NA, Polansky MM. Dietary intake of calcium, chromium, copper, iron, magnesium, manganese, and zinc: duplicate plate values corrected using derived nutrient intake. *J Am Diet Assoc* 1993;93:462-4.
56. Danks DM. Copper deficiency in humans. *Ann.Rev.Nutr.* 1988;8:235-57.
57. Anderson RA, Bryden NA, Polansky MM. Dietary chromium intake. Freely chosen diets, institutional diet, and individual foods. *Biol Trace Elem Res* 1992;32:117-21.
58. Anderson RA, Kozlovsky AS. Chromium intake, absorption and excretion of subjects consuming self-selected diets. *Am.J.Clin.Nutr.* 1985;41:1177-83.
59. Gibson RS, MacDonald AC, Martinez OB. Dietary chromium and manganese intakes of a selected sample of Canadian elderly women. *Hum Nutr Appl.Nutr* 1985;39:43-52.
60. Kumpulainen JT. Chromium content of foods and diets. *Biol Trace Elem Res* 1992;32:9-18.
61. Mahalko JR, Bennion M. The effect of parity and time between pregnancies on maternal hair chromium concentration. *Am.J.Clin.Nutr.* 1976;29:1069-72.
62. Saner G. Urinary chromium excretion during pregnancy and its relationship with intravenous glucose loading. *Am.J.Clin.Nutr.* 1981;34:1676-9.
63. Saner G. The effect of parity on maternal hair chromium concentration and the changes during pregnancy. *Am.J.Clin.Nutr.* 1981;34:853-5.
64. Ding WJ, Chai ZF, Duan P, Feng WY, Qian QF. Serum and urine chromium concentrations in elderly diabetics. *Biological Trace Element Research* 1998;63:231-7.
65. Kant AK, Schatzkin A, Block G, Ziegler RG, Nestle M. Food group intake patterns and associated nutrient profiles of the US population. *J.Am.Diet.Assoc.* 1991;91:1532-7.
66. Breslow RA, Subar AF, Patterson BH, Block G. Trends in food intake: The 1987 and 1992 National Health Interview Surveys. *Nutr.Cancer* 1997;28:86-92.
67. Kant AK, Schatzkin A. Consumption of energy-dense, nutrient-poor foods by the US population: effect on nutrient profiles. *J.Am.Coll.Nutr.* 1994;13:285-91.
68. Block G. Dietary guidelines and the results of food consumption surveys. *Am.J Clin.Nutr.* 1991;53:356S-7S.
69. Cutler RG. Antioxidants and aging. *Am.J.Clin.Nutr.* 1991;53:373S-9S.
70. Ames BN. Micronutrients prevent cancer and delay aging. *Toxicol.Lett.* 1998;102-103:5-18:5-18.
71. Dreosti IE. Nutrition, cancer, and aging. *Ann.NY Acad.Sci.* 1998;854:371-7.
72. Ames BN. Micronutrient deficiencies - A major cause of DNA damage. *Ann.NY Acad.Sci.* 1999;889:87-106.
73. Food and Nutrition Board, National Research Council. Recommended Dietary Allowances. Washington, D.C.: National Academy Press, 1989.

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74. Herbert V, Das KC. Folic Acid and Vitamin B₁₂. In: Shils ME, Olson JA, Shike M, eds. *Modern Nutrition in Health and Disease*. Philadelphia: Lea & Febiger 1988:388-416.
75. Kim Y-I. Folate and carcinogenesis: Evidence, mechanisms, and implications. *J.Nutr. Biochem* 1999;10:66-88.
76. Kim Y. Folate and cancer prevention: A new medical application of folate beyond hyperhomocysteinemia and neural tube defects. *Nutrition reviews* 1999;57:314-21.
77. Glynn SA, Albanes D. Folate and cancer: A review of the literature. *Nutr.Cancer* 1994;22:101-19.
78. Mason JB, Levesque T. Folate: effects on carcinogenesis and the potential for cancer chemoprevention. *Oncology (Huntingt.)* 1996;10:1727-3.
79. Fraga CG, Motchnik PA, Shigenaga MK, Helbock HJ, Jacob RA, Ames BN. Ascorbic acid protects against endogenous oxidative DNA damage in human sperm. *Proc Natl Acad.Sci.U.S A* 1991;88:11003-6.
80. Cooke MS, Evans MD, Podmore ID et al. Novel repair action of vitamin C upon in vivo oxidative DNA damage. *FEBS Lett.* 1998;439:363-7.
81. Sweetman SF, Strain JJ, McKelvey-Martin VJ. Effect of antioxidant vitamin supplementation on DNA damage and repair in human lymphoblastoid cells. *Nutr Cancer* 1997;27:122-30.
82. Matos HR, Di Mascio P, Medeiros MHG. Protective effect of lycopene on lipid peroxidation and oxidative DNA damage in cell culture. *Archives of Biochemistry and Biophysics* 2000;383:56-9.
83. Porrini M, Riso P. Lymphocyte lycopene concentration and DNA protection from oxidative damage is increased in women after a short period of tomato consumption. *J.Nutr.* 2000;130:189-92.
84. Riso P, Pinder A, Santangelo A, Porrini M. Does tomato consumption effectively increase the resistance of lymphocyte DNA to oxidative damage? *Am.J.Clin.Nutr.* 1999;69:712-8.
85. Giovannucci E. Tomatoes, tomato-based products, lycopene, and cancer: Review of the epidemiologic literature. *J.Natl.Cancer Inst.* 1999;91:317-31.
86. Rao AV, Agarwal S. Role of lycopene as antioxidant carotenoid in the prevention of chronic diseases: A review. *Nutr Res* 1999;19:305-23.
87. Collins AR, Olmedilla B, Southon S, Granado F, Duthie SJ. Serum carotenoids and oxidative DNA damage in human lymphocytes. *Carcinogenesis* 1998;19:2159-62.
88. Haegele AD, Gillette C, O'Neill C et al. Plasma xanthophyll carotenoids correlate inversely with indices of oxidative DNA damage and lipid peroxidation. *Cancer Epidemiol.Biomarkers Prev.* 2000;9:421-5.
89. Pool-Zobel BL, Bub A, Müller H, Wollowski I, Rechkemper G. Consumption of vegetables reduces genetic damage in humans: first results of a human intervention trial with carotenoid-rich foods. *Carcinogenesis* 1997;18:1847-50.
90. Hu JJ, Chi CX, Frenkel K et al. α -tocopherol dietary supplement decreases titers of antibody against 5-hydroxymethyl-2'-deoxyuridine (HMdU). *Cancer Epidemiol.Biomarkers Prev.* 1999;8:693-8.
91. Lee BM, Lee SK, Kim HS. Inhibition of oxidative DNA damage, 8-OHdG, and carbonyl contents in smokers treated with antioxidants (vitamin E, vitamin C, β -carotene and red ginseng). *Cancer Letters* 1998;132:219-27.
92. Hartmann A, Niess AM, Grunert-Fuchs M, Poch B, Speit G. Vitamin E prevents exercise-induced DNA damage. *Mutat.Res* 1995;346:195-202.
93. Devasagayam TP, Subramanian M, Pradhan DS, Sies H. Prevention of singlet oxygen-induced DNA damage by lipoate. *Chem.Biol.Interact.* 1993;86:79-92.
94. Leanderson P, Faresjö ÅO, Tagesson C. Green tea polyphenols inhibit oxidant-induced DNA strand breakage in cultured lung cells. *Free Radical Biol Med* 1997;23:235-42.
95. Sai K, Kai S, Umemura T et al. Protective effects of green tea on hepatotoxicity, oxidative DNA damage and cell proliferation in the rat liver, induced by repeated oral administration of 2-nitropropane. *Food Chem.Toxicol.* 1998;36:1043-5.
96. Johnson MK, Loo G. Effects of epigallocatechin gallate and quercetin on oxidative damage to cellular DNA. *Mutat.Res.DNA Repair* 2000;459:211-8.
97. Klaunig JE, Xu Y, Han C et al. The effect of tea consumption on oxidative stress in smokers and nonsmokers. *Proc Soc Exp Biol Med* 1999;220:249-54.
98. Duthie SJ, Collins AR, DUTHIE GG, Dodson VL. Quercetin and myricetin protect against hydrogen peroxide-induced DNA damage (strand breaks and oxidised pyrimidines) in human lymphocytes. *Mutat.Res.Genet.Toxicol.Envion.Mutagen.* 1997;393:223-31.
99. Lean ME, Noroozi M, Kelly I et al. Dietary flavonols protect diabetic human lymphocytes against oxidative damage to DNA. *Diabetes* 1999;48:176-81.
100. Cai QY, Rahn RO, Zhang RW. Dietary flavonoids, quercetin, luteolin and genistein, reduce oxidative DNA damage and lipid peroxidation and quench free radicals. *Cancer Letters* 1997;119:99-107.
101. Giles D, Wei H. Effect of structurally related flavones-isoflavones on hydrogen peroxide production and oxidative DNA damage in phorbol ester-stimulated HL-60 cells. *Nutr.Cancer* 1997;29:77-82.
102. Duthie SJ, Ma A, Ross MA, Collins AR. Antioxidant supplementation decreases oxidative DNA damage in human lymphocytes. *Cancer Res.* 1996;56:1291-5.
103. Huang HE, Helzlsouer KJ, Appel LJ. The effects of vitamin C and vitamin E on oxidative DNA damage: Results from a randomized controlled trial. *Cancer Epidemiol.Biomarkers Prev.* 2000;9:647-52.
104. Prieme H, Loft S, Nyssonen K, Salonen JT, Poulsen HE. No effect of supplementation with vitamin E, ascorbic acid, or coenzyme Q10 on oxidative DNA damage estimated by 8-oxo-7,8-dihydro-2'-deoxyguanosine excretion in smokers. *Am.J.Clin.Nutr.* 1997;65:503-7.
105. Sastre J, Pallardó FV, De la Asunción JG, Viña J. Mitochondria, oxidative stress and aging. *Free Radic.Res.* 2000;32:189-98.

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106. Lenaz G, D'Aurelio M, Pich MM et al. Mitochondrial bioenergetics in aging. *Biochim.Biophys.Acta Bio-Energetics* 2000;1459:397-404.
107. Shigenaga MK, Hagen TM, Ames BN. Oxidative damage and mitochondrial decay in aging. *Proc.Natl.Acad.Sci.U.S.A.* 1994;91:10771-8.
108. Hagen TM, Wehr CM, Ames BN. Mitochondrial decay in aging. *Ann NY Acad Sci* 1998;854:214-23.
109. Packer L, Witt EH, Tritschler HJ. Alpha-lipoic acid as a biological antioxidant. *Free Radic.Biol.Med.* 1995;19:227-50.
110. Suzuki YJ, Tsuchiya M, Packer L. Thiocetic acid and dihydrolipoic acid are novel antioxidants which interact with reactive oxygen species [published erratum appears in *Free Radic Res Commun* 1992;17(2):155]. *Free Radic.Res.Comm.* 1991;15:255-63.
111. Hagen TM, Ingersoll RT, Lykkesfeldt J et al. (R)- α -lipoic acid-supplemented old rats have improved mitochondrial function, decreased oxidative damage, and increased metabolic rate. *FASEB J.* 1999;13:411-8.
112. Khanna S, Atalay S, Laaksonen DE, Gul M, Roy S, Sen CK. α -lipoic acid supplementation: tissue glutathione homeostasis at rest and after exercise. *J.Appl.Physiol.* 1999;86:1191-6.
113. Sen CK. Glutathione homeostasis in response to exercise training and nutritional supplements. *Mol.Cell.Biochem.* 1999;196:31-42.
114. Nohl H, Gille L. Evaluation of the antioxidant capacity of ubiquinol and dihydrolipoic acid. *Z.Naturforsch.(C)* 1998;53:250-3.
115. Packer L. Protective role of vitamin E in biological systems. *Am.J.Clin.Nutr.* 1991;53:1050S-5S.
116. Sies H, Stahl W, Sundquist AR. Antioxidant functions of vitamins E and C, beta-carotene, and other carotenoids. *Ann.N.Y.Acad.Sci.* 1992;669:7-33.
117. Frei B. Reactive oxygen species and antioxidant vitamins: Mechanisms of action. *Am.J.Med.* 1994;97 Suppl. 3A:5S-13S.
118. Beyer RE. The role of ascorbate in antioxidant protection of biomembranes: Interaction with vitamin E and coenzyme Q. *J.Bioenerg.Biomembr.* 1994;26:349-58.
119. Friedrichson T, Kalbach HL, Buck P, van Kuijk FJ. Vitamin E in macular and peripheral tissues of the human eye. *Curr Eye Res* 1995;14:693-701.
120. Kritchevsky SB, Shimakawa T, Tell GS et al. Dietary antioxidants and carotid artery wall thickness. The ARIC Study. *Atherosclerosis Risk in Communities Study. Circulation* 1995;92:2142-50.
121. Carpenter KLH, Cheeseman KH, Van der Veen C, Taylor SE, Walker MK, Mitchinson MJ. Depletion of alpha-tocopherol in human atherosclerotic lesions. *Free Radic.Res.* 1995;23:549-58.
122. Devaraj S, Jialal I. The effects of alpha-tocopherol on critical cells in atherogenesis. *Curr.Opin.Lipidol.* 1998;9:11-5.
123. Diaz MN, Frei B, Vita JA, Keaney JFJ. Antioxidants and atherosclerotic heart disease. *N.Engl.J Med* 1997;337:408-16.
124. Esterbauer H, Striegl G, Puhl H et al. The role of vitamin E and carotenoids in preventing oxidation of low density lipoproteins. *Ann.N.Y.Acad.Sci.* 1989;570:254-67.
125. Jialal I, Fuller CJ. Effect of vitamin E, vitamin C and beta-carotene on LDL oxidation and atherosclerosis. *Can J Cardiol* 1995;11 Suppl G:97G-103G.
126. Androne L, Gavan NA, Veresiu IA, Orasan R. *In vivo* effect of lipoic acid on lipid peroxidation in patients with diabetic neuropathy. *In Vivo* 2000;14:327-30.
127. Biewenga GP, Haenen GR, BAST A. The role of lipoic acid in the treatment of diabetic polyneuropathy. *Drug Metab.Rev.* 1997;29:1025-54.
128. Borcea V, Nourooz-Zadeh J, Wolff SP et al. α -lipoic acid decreases oxidative stress even in diabetic patients with poor glycemic control and albuminuria. *Free Radic.Biol.Med.* 1999;26:1495-500.
129. Low PA, Nickander KK, Tritschler HJ. The roles of oxidative stress and antioxidant treatment in experimental diabetic neuropathy. *Diabetes* 1997;46:S38-S42.
130. Mitsui Y, Schmelzer JD, Zollman PJ, Mitsui M, Tritschler HJ, Low PA. Alpha-lipoic acid provides neuroprotection from ischemia-reperfusion injury of peripheral nerve. *J.Neurol.Sci.* 1999;163:11-6.
131. Ziegler D, Reljanovic M, Mehnert H, Gries FA. α -Lipoic acid in the treatment of diabetic polyneuropathy in Germany: Current evidence from clinical trials. *Exp.Clin.Endocrinol.Diabetes* 1999;107:421-30.
132. Packer L, Tritschler HJ, Wessel K. Neuroprotection by the metabolic antioxidant α -lipoic acid. *Free Radical Biol Med* 1997;22:359-78.
133. Ames BN, Shigenaga MK, Hagen TM. Oxidants, antioxidants, and the degenerative diseases of aging. *Proc.Natl.Acad.Sci.U.S.A.* 1993;90:7915-22.
134. Hankinson SE, Stampfer MJ, Seddon JM et al. Nutrient intake and cataract extraction in women: a prospective study. *Brit.Med.J.* 1992;305:335-9.
135. Jacques PF, Taylor A, Hankinson SE et al. Long-term vitamin C supplement use and prevalence of early age-related lens opacities. *Am.J.Clin.Nutr.* 1997;66:911-6.
136. Knekt P, Heliovaara M, Rissanen A, Aromaa A, Aaran RK. Serum antioxidant vitamins and risk of cataract. *Brit.Med.J.* 1992;305:1392-4.
137. Leske MC, Chylack LT, Jr., He QM et al. Antioxidant vitamins and nuclear opacities - The longitudinal study of cataract. *Ophthalmology* 1998;105:831-6.
138. Lyle BJ, Mares-Perlman JA, Klein BEK, Klein R, Greger JL. Antioxidant intake and risk of incident age-related nuclear cataracts in the Beaver Dam Eye Study. *Am.J.Epidemiol.* 1999;149:801-9.
139. Manson JE, Gaziano JM, Jonas MA, Hennekens CH. Antioxidants and cardiovascular disease: a review. *J Am Coll Nutr* 1993;12:426-32.
140. Gey KF. Vitamins E plus C and interacting conutrients required for optimal health. *BioFactors* 1998;7:113-74.
141. Anderson JW, Gowri MS, Turner J et al. Antioxidant supplementation effects on low-density lipoprotein oxidation

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

- for individuals with type 2 diabetes mellitus. *J.Am.Coll.Nutr.* 1999;18:451-61.
142. Mosca L, Rubenfire M, Mandel C et al. Antioxidant nutrient supplementation reduces the susceptibility of low density lipoprotein to oxidation in patients with coronary artery disease. *J.Am.Coll.Cardiol.* 1997;30:392-9.
 143. Stampfer MJ, Rimm EB. Epidemiologic evidence for vitamin E in prevention of cardiovascular disease. *Am.J.Clin.Nutr.* 1995;62:1365S-9S.
 144. Spencer AP, Carson DS, Crouch MA. Vitamin E and coronary artery disease. *Arch Intern.Med* 1999;159:1313-20.
 145. Stephens NG, Parsons A, Schofield PM, Kelly F, Cheeseman K, Mitchinson MJ. Randomised controlled trial of vitamin E in patients with coronary disease: Cambridge Heart Antioxidant Study (CHAOS). *Lancet* 1996;347:781-6.
 146. Chan AC. Vitamin E and atherosclerosis. *J.Nutr.* 1998;128:1593-6.
 147. Simons LA, von Konigsmark M, Balasubramaniam S. What dose of vitamin E is required to reduce susceptibility of LDL to oxidation? *Aust.N.Z.J Med* 1996;26:496-503.
 148. Princen HM, van Duyvenvoorde W, Buytenhek R et al. Supplementation with low doses of vitamin E protects LDL from lipid peroxidation in men and women. *Arterioscler.Thromb.Vasc.Biol* 1995;15:325-33.
 149. Calzada C, Bruckdorfer KR, Rice-Evans CA. The influence of antioxidant nutrients on platelet function in healthy volunteers. *Atherosclerosis* 1997;128:97-105.
 150. Azen SP, Qian DJ, Mack WJ et al. Effect of supplementary antioxidant vitamin intake on carotid arterial wall intima-media thickness in a controlled clinical trial of cholesterol lowering. *Circulation* 1996;94:2369-72.
 151. Davey PJ, Schulz M, Glikzman M, Dobson M, Aristides M, Stephens NG. Cost-effectiveness of vitamin E therapy in the treatment of patients with angiographically proven coronary narrowing (CHAOS trial). *Am.J.Cardiol.* 1998;82:414-7.
 152. Mottram P, Shige H, Nestel P. Vitamin E improves arterial compliance in middle-aged men and women. *Atherosclerosis* 1999;145:399-404.
 153. Acuff, R. V., Thedford, S. S., Hidioglou, N. N., Papas, A. M., and Odom Jr, T. A. Relative bioavailability of *RRR*- and *all-rac*- α -tocopheryl acetate in humans: studies using deuterated compounds. *Am.J.Clin.Nutr.* 60, 397-402. 1994.
 154. Ferslew KE, Acuff RV, Daigneault EA, Woolley TW, Stanton PEJ. Pharmacokinetics and bioavailability of the *RRR* and all racemic stereoisomers of alpha-tocopherol in humans after single oral administration. *J Clin Pharmacol.* 1993;33:84-8.
 155. Acuff RV, Thedford SS, Hidioglou NN, Papas AM, Odom TAJ. Relative bioavailability of *RRR*- and *all-rac*-alpha-tocopheryl acetate in humans: studies using deuterated compounds. *Am.J.Clin.Nutr.* 1994;60:397-402.
 156. Burton, G. W., Traber, M. G., Acuff, R. V., Walters, D. N., Kayden, H., Hughes, L., and Ingold, K. U. Human plasma and tissue alpha-tocopherol concentrations in response to supplementation with deuterated natural and synthetic vitamin E. *Am.J.Clin.Nutr.* 67(4), 669-684. 1998.
 157. Fauteck JD, Schmidt H, Lerchl A, Kurlemann G, Wittkowski W. Melatonin in epilepsy: First results of replacement therapy and first clinical results. *Biol.Signals* 1999;8:105-10.
 158. Bendich A, Langseth L. The health effects of vitamin C supplementation: A review. *J.Am.Coll.Nutr.* 1995;14:124-36.
 159. Carr AC, Zhu BZ, Frei B. Potential antiatherogenic mechanisms of ascorbate (vitamin C) and α -tocopherol (vitamin E). *Circ.Res.* 2000;87:349-54.
 160. Jacob RA. Vitamin C nutrition and risk of atherosclerotic heart disease. *Nutrition reviews* 1998;56:334-7.
 161. Niki E, Noguchi N, Tsuchihashi H, Gotoh N. Interaction among vitamin C, vitamin E, and beta-carotene. *Am.J.Clin.Nutr.* 1995;62:1322S-6S.
 162. Tanaka K, Hashimoto T, Tokumaru S, Iguchi H, Kojo S. Interactions between vitamin C and vitamin E are observed in tissues of inherently scorbutic rats. *J.Nutr.* 1997;127:2060-4.
 163. Fuller CJ, Grundy SM, Norkus EP, Jialal I. Effect of ascorbate supplementation on low density lipoprotein oxidation in smokers. *Atherosclerosis* 1996;119:139-50.
 164. Fotherby MD, Williams JC, Forster LA, Craner P, Ferns GA. Effect of vitamin C on ambulatory blood pressure and plasma lipids in older persons. *J.Hypertens.* 2000;18:411-5.
 165. Jacques PF. Effects of vitamin C on high-density lipoprotein cholesterol and blood pressure. *J Am Coll Nutr* 1992;11:139-44.
 166. Ness AR, Khaw KT, Bingham S, Day NE. Vitamin C status and blood pressure. *J Hypertens.* 1996;14:503-8.
 167. Ness AR, Chee D, Elliott P. Vitamin C and blood pressure--an overview. *J Hum.Hypertens.* 1997;11:343-50.
 168. Salonen JT, Salonen R, Ihanainen M et al. Vitamin C deficiency and low linolenate intake associated with elevated blood pressure: the Kuopio Ischaemic Heart Disease Risk Factor Study. *J.Hypertens.Suppl.* 1987;5:S521-4.
 169. Tofler GH, Stec JJ, Stubbe I et al. The effect of vitamin C supplementation on coagulability and lipid levels in healthy male subjects. *Thrombosis Research* 2000;100:35-41.
 170. Kaufmann PA, Gnecci-Ruscone T, Di Terlizzi M, Schäfers KP, Lüscher TF, Camici PG. Coronary heart disease in smokers - Vitamin C restores coronary microcirculatory function. *Circulation* 2000;102:1233-8.
 171. Gokce N, Keaney JF, Jr., Frei B et al. Long-term ascorbic acid administration reverses endothelial vasomotor dysfunction in patients with coronary artery disease. *Circulation* 1999;101:342-6.
 172. Hirai N, Kawano H, Hirashima O et al. Insulin resistance and endothelial dysfunction in smokers: effects of vitamin C. *Am.J.Physiol.Heart Circ.Physiol.* 2000;279:H1172-H1178.
 173. Hirashima O, Kawano H, Motoyama T et al. Improvement of endothelial function and insulin sensitivity with vitamin c in patients with coronary spastic angina - Possible role of reactive oxygen species. *J.Am.Coll.Cardiol.* 2000;35:1860-6.
 174. Levine GN, Frei B, Koulouris SN, Gerhard MD, Keaney JFJ, Vita JA. Ascorbic acid reverses endothelial vasomotor dysfunction in patients with coronary artery disease. *Circulation* 1996;93:1107-13.

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

175. Watanabe H, Kakihana M, Ohtsuka S, Sugishita Y. Randomized, double-blind, placebo-controlled study of the preventive effect of supplemental oral vitamin C on attenuation of development of nitrate tolerance. *J.Am.Coll.Cardiol.* 1998;31:1323-9.
176. Weber C, Erl W, Weber K, Weber PC. Increased adhesiveness of isolated monocytes to endothelium is prevented by vitamin C intake in smokers. *Circulation* 1996;93:1488-92.
177. Wilkinson IB, Megson IL, MacCallum H, Sogo N, Cockcroft JR, Webb DJ. Oral vitamin c reduces arterial stiffness and platelet aggregation in humans. *J.Cardiovasc.Pharmacol.* 1999;34:690-3.
178. Gale CR, Martyn CN, Winter PD, Cooper C. Vitamin C and risk of death from stroke and coronary heart disease in cohort of elderly people. *Br.Med.J.* 1995;310:1563-6.
179. Simon JA, Hudes ES, Browner WS. Serum ascorbic acid and cardiovascular disease prevalence in US adults. *Epidemiology* 1998;9:316-21.
180. Nyyssönen K, Parviainen MT, Salonen R, Tuomilehto J, Salonen JT. Vitamin C deficiency and risk of myocardial infarction: Prospective population study of men from eastern Finland. *Bmj* 1997;314:634-8.
181. Knekt P, Reunanen A, Järvinen R et al. Antioxidant vitamin intake and coronary mortality in a longitudinal population study. *Am.J.Epidemiol.* 1994;139:1180-9.
182. Enstrom JE, Kanim LE, Klein MA. Vitamin C intake and mortality among a sample of the United States population. *Epidemiology* 1992;3:194-202.
183. Levine M, Conry-Cantilena C, Wang Y et al. Vitamin C pharmacokinetics in healthy volunteers: evidence for a recommended dietary allowance. *Proc Natl.Acad.Sci U S A* 1996;93:3704-9.
184. Graumlich JF, Ludden TM, Conry-Cantilena C, Cantilena LR, Jr., Wang YH, Levine M. Pharmacokinetic model of ascorbic acid in healthy male volunteers during depletion and repletion. *Pharm.Res.* 1997;14:1133-9.
185. Lachance P. Dietary intake of carotenes and the carotene gap. *Clin.Nutr.* 1988;7:118-22.
186. Kohlmeier L, Hastings SB. Epidemiologic evidence of a role of carotenoids in cardiovascular disease prevention. *Am.J.Clin.Nutr.* 1995;62:1370S-6S.
187. Kritchevsky SB. β -carotene, carotenoids and the prevention of coronary heart disease. *J.Nutr.* 1999;129:5-8.
188. Morris DL, Kritchevsky SB, Davis CE. Serum carotenoids and coronary heart disease: The Lipid Research Clinics Coronary Primary Prevention Trial and Follow- up Study. *JAMA* 1994;272:1439-41.
189. Hennekens CH, Buring JE, Manson JE et al. Lack of effect of long-term supplementation with beta carotene on the incidence of malignant neoplasms and cardiovascular disease. *N.Engl.J Med.* 1996;334:1145-9.
190. Kritchevsky SB, Tell GS, Shimakawa T et al. Provitamin A carotenoid intake and carotid artery plaques: the Atherosclerosis Risk in Communities Study. *Am.J.Clin.Nutr.* 1998;68:726-33.
191. Arab L, Steck S. Lycopene and cardiovascular disease. *Am.J.Clin.Nutr.* 2000;71:1691S-5S.
192. Rao AVR, Agarwal S. Role of antioxidant lycopene in cancer and heart disease. *J.Am.Coll.Nutr.* 2000;19:563-9.
193. Agarwal S, Rao AV. Tomato lycopene and low density lipoprotein oxidation: A human dietary intervention study. *Lipids* 1998;33:981-4.
194. Chopra M, O'Neill ME, Keogh N, Wortley G, Southon S, Thurnham DI. Influence of increased fruit and vegetable intake on plasma and lipoprotein carotenoids and LDL oxidation in smokers and nonsmokers. *Clinical Chemistry* 2000;46:1818-29.
195. D'Odorico A, Martinez D, Kiechl S et al. High plasma levels of β - and α -carotene are associated with a lower risk of atherosclerosis - Results from the Bruneck study. *Atherosclerosis* 2000;153:231-9.
196. Kontush A, Spranger T, Reich A, Baum K, Beisiegel U. Lipophilic antioxidants in blood plasma as markers of atherosclerosis: the role of β -carotene and gamma-tocopherol. *Atherosclerosis* 1999;144:117-22.
197. Iribarren C, Folsom AR, Jacobs DR, Jr., Gross MD, Belcher JD, Eckfeldt JH. Association of serum vitamin levels, LDL susceptibility to oxidation, and autoantibodies against MDA-LDL with carotid atherosclerosis - A case-control study. *Arterioscler.Thromb.Vasc.Biol.* 1997;17:1171-7.
198. Suter PM. Effect of vitamin E, vitamin C, and β -carotene on stroke risk. *Nutrition reviews* 2000;58:184-7.
199. Bravo L. Polyphenols: Chemistry, dietary sources, metabolism, and nutritional significance. *Nutrition reviews* 1998;56:317-33.
200. Hertog MG, Feskens EJ, Hollman PC, Katan MB, Kromhout D. Dietary antioxidant flavonoids and risk of coronary heart disease: the Zutphen Elderly Study. *Lancet* 1993;342:1007-11.
201. Hertog MG, Kromhout D, Aravanis C et al. Flavonoid intake and long-term risk of coronary heart disease and cancer in the seven countries study [published erratum appears in *Arch Intern Med* 1995 Jun 12;155(11):1184]. *Arch.Intern.Med* 1995;155:381-6.
202. Knekt P, Jarvinen R, Reunanen A, Maatela J. Flavonoid intake and coronary mortality in Finland: a cohort study. *Brit.Med.J.* 1996;312:478-81.
203. Keli SO, Hertog MG, Feskens EJ, Kromhout D. Dietary flavonoids, antioxidant vitamins, and incidence of stroke: the Zutphen study. *Arch.Intern.Med* 1996;156:637-42.
204. Yochum L, Kushi LH, Meyer K, Folsom AR. Dietary flavonoid intake and risk of cardiovascular disease in postmenopausal women. *Am J Epidemiol.* 1999;149:943-9.
205. Schramm DD, German JB. Potential effects of flavonoids on the etiology of vascular disease. *J.Nutr.Biochem.* 1998;9:560-6.
206. Yang TTC, Koo MWL. Inhibitory effect of Chinese green tea on endothelial cell-induced LDL oxidation. *Atherosclerosis* 2000;148:67-73.
207. Miura Y, Chiba T, Miura S et al. Green tea polyphenols (flavan 3-ols) prevent oxidative modification of low density lipoproteins: An ex vivo study in humans. *J.Nutr.Biochem.* 2000;11:216-22.

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

208. Hodgson JM, Proudfoot JM, Croft KD, Puddey IB, Mori TA, Beilin LJ. Comparison of the effects of black and green tea on *in vitro* lipoprotein oxidation in human serum. *J.Sci.Food Agric.* 1999;79:561-6.
209. Ishikawa T, Suzukawa M, Ito T et al. Effect of tea flavonoid supplementation on the susceptibility of low-density lipoprotein to oxidative modification. *Am.J.Clin.Nutr.* 1997;66:261-6.
210. Kono S, Shinchi K, Ikeda N, Yanai F, Imanishi K. Green tea consumption and serum lipid profiles: a cross-sectional study in northern Kyushu, Japan. *Prev.Med.* 1992;21:526-31.
211. Frankel E. Activity of wine and grape phenolic antioxidants in human LDL. *BioFactors* 1997;6:433-5.
212. Kapiotis S, Hermann M, Held I, Seelos C, Ehringer H, Gmeiner BM. Genistein, the dietary-derived angiogenesis inhibitor, prevents LDL oxidation and protects endothelial cells from damage by atherogenic LDL. *Arterioscler.Thromb.Vasc.Biol.* 1997;17:2868-74.
213. Lichtenstein AH. Soy protein, isoflavones and cardiovascular disease risk. *J.Nutr.* 1998;128:1589-92.
214. Merz-Demlow BE, Duncan AM, Wangen KE et al. Soy isoflavones improve plasma lipids in normocholesterolemic, premenopausal women. *Am.J.Clin.Nutr.* 2000;71:1462-9.
215. Anthony MS, Clarkson TB, Williams JK. Effects of soy isoflavones on atherosclerosis: potential mechanisms. *Am.J.Clin.Nutr.* 1998;68:1390S-3S.
216. Chiechi LM. Dietary phytoestrogens in the prevention of long-term postmenopausal diseases. *Int.J.Gynecol.Obstet.* 1999;67:39-40.
217. Jenkins DJA, Kendall CWC, Garsetti M et al. Effect of soy protein foods on low-density lipoprotein oxidation and *ex vivo* sex hormone receptor activity - A controlled crossover trial. *Metabolism* 2000;49:537-43.
218. Tikkanen MJ, Adlercreutz H. Dietary soy-derived isoflavone phytoestrogens - Could they have a role in coronary heart disease prevention? *Biochemical Pharmacology* 2000;60:1-5.
219. Wiseman H, O'Reilly JD, Adlercreutz H et al. Isoflavone phytoestrogens consumed in soy decrease F₂-isoprostane concentrations and increase resistance of low-density lipoprotein to oxidation in humans. *Am.J.Clin.Nutr.* 2000;72:395-400.
220. Pignatelli P, Pulcinelli FM, Celestini A et al. The flavonoids quercetin and catechin synergistically inhibit platelet function by antagonizing the intracellular production of hydrogen peroxide. *Am.J.Clin.Nutr.* 2000;72:1150-5.
221. Justesen U, Knuthsen P, Leth T. Determination of plant polyphenols in Danish foodstuffs by HPLC-UV and LC-MS detection. *Cancer Letters* 1997;114:165-7.
222. Dragsted LO, Strube M, Leth T. Dietary levels of plant phenols and other non-nutritive components: Could they prevent cancer? *Eur.J.Cancer Prev.* 1997;6:522-8.
223. Linseisen J, Radtke J, Wolfram G. Flavonoidzufuhr Erwachsener in einem bayerischen Teilkollektiv der Nationalen Verzehrsstudie. *Z.Ernahrungswiss.* 1997;36:403-12.
224. Ubbink JB. Homocysteine--an atherogenic and a thrombogenic factor? *Nutr Rev* 1995;53:323-5.
225. McCully KS. Chemical pathology of homocysteine. I. Atherogenesis. *Ann.Clin Lab.Sci.* 1993;23:477-93.
226. Ubbink JB, Vermaak WJ, Bennett JM, Becker PJ, van Staden DA, Bissbort S. The prevalence of homocysteinemia and hypercholesterolemia in angiographically defined coronary heart disease. *Klin.Wochenschr.* 1991;69:527-34.
227. Wald NJ, Watt HC, Law MR, Weir DG, McPartlin J, Scott JM. Homocysteine and ischemic heart disease: results of a prospective study with implications regarding prevention. *Arch.Intern.Med* 1998;158:862-7.
228. Arnesen E, Refsum H, Bonna KH, Ueland PM, Forde OH, Nordrehaug JE. Serum total homocysteine and coronary heart disease. *Int.J.Epidemiol* 1995;24:704-9.
229. Graham, I. M., Daly, L. E., Refsum, H. M., et al. Plasma homocysteine as a risk factor for vascular disease. The European Concerted Action Project. *JAMA* 277(22), 1775-1781. 6-11-1997.
230. Nygard O, Nordrehaug JE, Refsum H, Ueland PM, Farstad M, Vollset SE. Plasma homocysteine levels and mortality in patients with coronary artery disease. *N Engl J Med* 1997;337:230-6.
231. Brattström L, Zhang Y, Hurtig M et al. A common methylenetetrahydrofolate reductase gene mutation and longevity. *Atherosclerosis* 1998;141:315-9.
232. Folsom AR, Nieto FJ, McGovern PG et al. Prospective study of coronary heart disease incidence in relation to fasting total homocysteine, related genetic polymorphisms, and B vitamins: the Atherosclerosis Risk in Communities (ARIC) study. *Circulation* 1998;98:204-10.
233. Dierkes J, Kroesen M, Pietrzik K. Folic acid and Vitamin B6 supplementation and plasma homocysteine concentrations in healthy young women. *Int.J.Vitam.Nutr Res* 1998;68:98-103.
234. Malinow MR, Nieto FJ, Kruger WD et al. The effects of folic acid supplementation on plasma total homocysteine are modulated by multivitamin use and methylenetetrahydrofolate reductase genotypes. *Arterioscler.Thromb.Vasc.Biol.* 1997;17:1157-62.
235. Ward M, McNulty H, McPartlin J, Strain JJ, Weir DG, Scott JM. Plasma homocysteine, a risk factor for cardiovascular disease, is lowered by physiological doses of folic acid. *Q.J.Med.* 1997;90:519-24.
236. Brönstrup A, Hages M, Prinz-Langenohl R, Pietrzik K. Effects of folic acid and combinations of folic acid and vitamin B-12 on plasma homocysteine concentrations in healthy, young women. *Am.J.Clin.Nutr.* 1998;68:1104-10.
237. Brouwer, I. A., van Duseldorp, M., Thomas, C. M. G., DURAN, M., and Et Al. Low-dose folic acid supplementation decreases plasma homocysteine concentrations: a randomized trial. *Am.J.Clin.Nutr.* 69, 99-104. 1999.
238. Durlach J, Bac P, Bara M, Guiet-Bara A. Cardiovasoprotective foods and nutrients: possible importance of magnesium intake. *Magnes.Res.* 1999;12:57-61.
239. Laurant P, Touyz RM. Physiological and pathophysiological role of magnesium in the cardiovascular system: implications in hypertension. *J.Hypertens.* 2000;18:1177-91.
240. Itoh K, Kawasaka T, Nakamura M. The effects of high oral magnesium supplementation on blood pressure, serum lipids

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

- and related variables in apparently healthy Japanese subjects. *Br.J.Nutr.* 1997;78:737-50.
241. Kawano Y, Matsuoka H, Takishita S, Omae T. Effects of magnesium supplementation in hypertensive patients: assessment by office, home, and ambulatory blood pressures. *Hypertension* 1998;32:260-5.
 242. Wirell MP, Wester PO, Stegmayr BG. Nutritional dose of magnesium in hypertensive patients on beta blockers lowers systolic blood pressure: A double-blind, cross-over study. *J.Intern.Med.* 1994;236:189-95.
 243. Witteman JCM, Grobbee DE, Derkx FHM, Bouillon R, De Bruijn AM, Hofman A. Reduction of blood pressure with oral magnesium supplementation in women with mild to moderate hypertension. *Am.J.Clin.Nutr.* 1994;60:129-35.
 244. Plum-Wirell M, Stegmayr BG, Wester PO. Nutritional magnesium supplementation does not change blood pressure nor serum or muscle potassium and magnesium in untreated hypertension. A double-blind crossover study. *Magnes.Res.* 1994;7:277-83.
 245. Sacks FM, Willett WC, Smith A, Brown LE, Rosner B, Moore TJ. Effect on blood pressure of potassium, calcium, and magnesium in women with low habitual intake. *Hypertension* 1998;31:131-8.
 246. Shechter M, Merz CNB, Paul-Labrador M et al. Oral magnesium supplementation inhibits platelet-dependent thrombosis in patients with coronary artery disease. *Am.J.Cardiol.* 1999;84:152-6.
 247. Orlov MV, Brodsky MA, Douban S. A review of magnesium, acute myocardial infarction and arrhythmia. *J.Am.Coll.Nutr.* 1994;13:127-32.
 248. Sasaki S, Oshima T, Matsuura H et al. Abnormal magnesium status in patients with cardiovascular diseases. *Clinical Science* 2000;98:175-81.
 249. Cappuccio FP, Elliott P, Allender PS, Pryer J, Follman DA, Cutler JA. Epidemiologic association between dietary calcium intake and blood pressure: A meta-analysis of published data. *Am.J.Epidemiol.* 1995;142:935-45.
 250. Lijnen P, Petrov V. Dietary calcium, blood pressure and cell membrane cation transport systems in males. *J.Hypertens.* 1995;13:875-82.
 251. Gillman MW, Hood MY, Moore LL, Nguyen U-SDT, Singer MR, Andon MB. Effect of calcium supplementation on blood pressure in children. *J.Pediatr.* 1995;127:186-92.
 252. Kawano Y, Yoshimi H, Matsuoka H, Takishita S, Omae T. Calcium supplementation in patients with essential hypertension: assessment by office, home and ambulatory blood pressure. *J.Hypertens.* 1998;16:1693-9.
 253. Mccarron DA, Reusser ME. Finding consensus in the dietary calcium-blood pressure debate. *J.Am.Coll.Nutr.* 1999;18:398S-405S.
 254. Griffith LE, Guyatt GH, Cook RJ, Bucher HC, Cook DJ. The influence of dietary and nondietary calcium supplementation on blood pressure - An updated metaanalysis of randomized controlled trials. *Am.J.Hypertens.* 1999;12:84-92.
 255. Durlach J, Bac P, Durlach V, Rayssiguier Y, Bara M, Guiet-Bara A. Magnesium status and ageing: An update. *Magnes.Res.* 1998;11:25-42.
 256. Bronner F. Calcium and osteoporosis. *Am.J.Clin.Nutr.* 1994;60:831-6.
 257. Teegarden D, Weaver CM. Calcium supplementation increases bone density in adolescent girls. *Nutr Rev.* 1994;52:171-3.
 258. Lee WTK, Leung SSF, Leung DMY, Tsang HSY, Lau J, Cheng JCY. A randomized double-blind controlled calcium supplementation trial, and bone and height acquisition in children. *Br.J.Nutr.* 1995;74:125-39.
 259. Welten DC, Kemper HC, Post GB, van Staveren WA. A meta-analysis of the effect of calcium intake on bone mass in young and middle aged females and males. *J.Nutr.* 1995;125:2802-13.
 260. Renner E. Dairy calcium, bone metabolism, and prevention of osteoporosis. *J.Dairy.Sci.* 1994;77:3498-505.
 261. Reid IR, Ames RW, Evans MC, Gamble GD, Sharpe SJ. Long-term effects of calcium supplementation on bone loss and fractures in postmenopausal women: a randomized controlled trial. *Am J Med.* 1995;98:331-5.
 262. Chiu KM. Efficacy of calcium supplements on bone mass in postmenopausal women. *J.Gerontol.[A]* 1999;54:M275-M280.
 263. Looker AC, Harris TB, Madans JH, Sempos CT. Dietary calcium and hip fracture risk: the NHANES I Epidemiologic Follow-Up Study. *Osteoporos Int* 1993;3:4-84.
 264. Power ML, Heaney RP, Kalkwarf HJ et al. The role of calcium in health and disease. *Am.J.Obstet.Gynecol.* 1999;181:1560-9.
 265. Reid IR. The roles of calcium and vitamin D in the prevention of osteoporosis. *Endocrinol.Metab.Clin North Am* 1998;27:389-98.
 266. Food and Nutrition Board and Institute of Medicine. *Dietary Reference Intakes: Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride.* Prepublication Copy. 1997. Washington, D.C., National Academy Press.
 267. Sojka JE, Weaver CM. Magnesium supplementation and osteoporosis. *Nutr.Rev.* 1995;53:71-4.
 268. Stendig-Lindberg, G., Tepper, R., and Leichter, I. Trabecular bone density in a two year controlled trial of peroral magnesium in osteoporosis. *Magnesium Research* 6(2), 155-163. 1993.
 269. Paunier L. Effect of magnesium on phosphorus and calcium metabolism. *Monatsschr.Kinderheilkd.* 1992;140:S17-S20.
 270. Patti L, Maffettone A, Iovine C et al. Long-term effects of fish oil on lipoprotein subfractions and low density lipoprotein size in non-insulin-dependent diabetic patients with hypertriglyceridemia. *Atherosclerosis* 1999;146:361-7.
 271. Volpe SL, Taper LJ, Meacham S. The relationship between boron and magnesium status and bone mineral density in the human: a review. *Magnes.Res.* 1993;6:291-6.
 272. Martini LA. Magnesium supplementation and bone turnover. *Nutr.Rev.* 1999;57:227-9.
 273. Gallagher JC. The role of vitamin D in the pathogenesis and treatment of osteoporosis. *J Rheumatol.Suppl* 1996;45:15-8.
 274. Bouillon RA, Auwerx JH, Lissens WD, Pelemans WK. Vitamin D status in the elderly: seasonal substrate deficiency

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

- causes 1,25-dihydroxycholecalciferol deficiency. *Am.J.Clin.Nutr.* 1987;45:755-63.
275. Diamond T, Smerdely P, Kormas N, Sekel R, Vu T, Day P. Hip fracture in elderly men: the importance of subclinical vitamin D deficiency and hypogonadism. *Med J Aust.* 1998;169:138-41.
 276. Torgerson DJ, Kanis JA. Cost-effectiveness of preventing hip fractures in the elderly population using vitamin D and calcium. *Q.J.Med.* 1995;88:135-9.
 277. Ooms ME, Roos JC, Bezemer PD, van der Vijgh WJ, Bouter LM, Lips P. Prevention of bone loss by vitamin D supplementation in elderly women: a randomized double-blind trial. *J Clin Endocrinol.Metab.* 1995;80:1052-8.
 278. O'Brien KO. Combined calcium and vitamin D supplementation reduces bone loss and fracture incidence in older men and women. *Nutr Rev* 1998;56:148-50.
 279. Kaufman JM. Role of calcium and vitamin D in the prevention and the treatment of postmenopausal osteoporosis: an overview. *Clin Rheumatol.* 1995;14 Suppl 3:9-13.
 280. Gloth FM3, Gundberg CM, Hollis BW, Haddad JG, Jr., Tobin JD. Vitamin D deficiency in homebound elderly persons. *JAMA* 1995;274:1683-6.
 281. Kessenich CR, Rosen CJ. Vitamin D and bone status in elderly women. *Orthop.Nurs.* 1996;15:67-71.
 282. Holick, M. F. Environmental factors that influence the cutaneous production of vitamin D. *Am.J.Clin.Nutr.* 61 Suppl., 638S-645S. 1995.
 283. Binkley NC, Suttie JW. Vitamin K nutrition and osteoporosis. *J.Nutr.* 1995;125:1812-21.
 284. Vermeer, C., Jie, K.-S. G., and Knapen, M. H. J. Role of vitamin K in bone metabolism. *Annual Review of Nutrition* 15, 1-22. 1995.
 285. Dowd P, Ham S-W, Naganathan S, Hershline R. The mechanism of action of vitamin K. *Annu.Rev.Nutr.* 1995;15:419-40.
 286. Ferland G. The vitamin K-dependent proteins: an update. *Nutr Rev* 1998;56:223-30.
 287. Porter KH. Undercarboxylated osteocalcin: Indicator of vitamin K status and hip fracture risk? *Biochem.Arch.* 1999;15:225-37.
 288. Vermeer G, Schurgers LJ. A comprehensive review of vitamin K and vitamin K antagonists. *Hematol.Oncol.Clin.North Am.* 2000;14:339-53.
 289. Nielsen FH. Biochemical and physiologic consequences of boron deprivation in humans. *Environ.Health Perspect.* 1994;102 Suppl 7:59-63.
 290. Naghii MR, Samman S. The role of boron in nutrition and metabolism. *Prog.Food Nutr.Sci.* 1993;17:331-49.
 291. McCoy H, Kenney MA, Montgomery C, Irwin A, Williams L, Orrell R. Relation of boron to the composition and mechanical properties of bone. *Environ.Health Perspect.* 1994;102 Suppl 7:49-53.
 292. Nielsen FH. Ultratrace Minerals. In: Shils ME, Olson JA, Shike M, eds. *Modern Nutrition in Health and Disease.* Philadelphia: Lea & Febiger 1994:269-86.
 293. Newnham RE. Essentiality of boron for healthy bones and joints. *Environ.Health Perspect.* 1994;102 Suppl 7:83-5.
 294. Dupre JN, Keenan MJ, Hegsted M, Brudevold AM. Effects of dietary boron in rats fed a vitamin D-deficient diet. *Environ.Health Perspect.* 1994;102 Suppl 7:55-8.
 295. Hunt CD. The biochemical effects of physiologic amounts of dietary boron in animal nutrition models. *Environ.Health Perspect.* 1994;102 Suppl 7:35-43.
 296. Meacham SL, Taper LJ, Volpe SL. Effect of boron supplementation on blood and urinary calcium, magnesium, and phosphorus, and urinary boron in athletic and sedentary women. *Am.J.Clin.Nutr.* 1995;61:341-5.
 297. Meacham SL, Taper LJ, Volpe SL. Effects of boron supplementation on bone mineral density and dietary, blood, and urinary calcium, phosphorus, magnesium, and boron in female athletes. *Environ.Health Perspect.* 1994;102 Suppl 7:79-82.
 298. Nielsen FH, Shuler TR. Studies of the interaction between boron and calcium, and its modification by magnesium and potassium, in rats. Effects on growth, blood variables, and bone mineral composition. *Biol.Trace Elem.Res.* 1992;35:225-37.
 299. Hegsted M, Keenan MJ, Siver F, Wozniak P. Effect of boron on vitamin D deficient rats. *Biol.Trace Elem.Res.* 1991;28:243-55.
 300. Nielsen FH. Studies on the relationship between boron and magnesium in the formation and maintenance of bones. *J Am Coll Nutr* 1989;8:457 (abstr).
 301. Seaborn CD NF. Silicon: A nutritional beneficence for bones, brains and blood vessels? *Nutrition Today* 1993;28:13-6.
 302. Nielsen FH. Ultratrace elements in nutrition: Current knowledge and speculation. *J.Trace Elem.Exp.Med.* 1998;11:251-74.
 303. Carlisle EM. Silicon as a trace nutrient. *Sci.Total.Environ.* 1988;73:95-106.
 304. Seaborn, C. D. and Nielsen, F. H. Effects of germanium and silicon on bone mineralization. *Biol.Trace Elem.Res.* 42, 151-164. 1994.
 305. Seaborn CD, Nielsen FH. Response surface analysis of bone composition changes caused by dietary calcium and silicon. *FASEB J* 1993;7:A77.
 306. Rico H, Gallego-Lago JL, Hernández ER et al. Effect of silicon supplement on osteopenia induced by ovariectomy in rats. *Calcified Tissue International* 2000;66:53-5.
 307. Anderson JJ, Garner SC. The effects of phytoestrogens on bone. *Nutr Res* 1997;17:1617-32.
 308. Potter SM, Baum JA, Teng HY, Stillman RJ, Shay NF, Erdman JW, Jr. Soy protein and isoflavones: their effects on blood lipids and bone density in postmenopausal women. *Am.J.Clin.Nutr.* 1998;68:1375S-9S.
 309. Mertz W. Chromium in human nutrition: a review. *J.Nutr.* 1993;123:626-33.
 310. Anderson RA. Chromium, glucose intolerance and diabetes. *J.Am.Coll.Nutr.* 1998;17:548-55.

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

311. Vincent JB. Mechanisms of chromium action: Low-molecular-weight chromium-binding substance. *J.Am.Coll.Nutr.* 1999;18:6-12.
312. Freund H, Atamian S, Fischer JE. Chromium deficiency during total parenteral nutrition. *JAMA* 1979;241:496-8.
313. Jeejeebhoy KN, Chu RC, Marliss EB, Greenberg GR, Bruce-Robertson A. Chromium deficiency, glucose intolerance, and neuropathy reversed by chromium supplementation, in a patient receiving long-term total parenteral nutrition. *Am.J.Clin.Nutr.* 1977;30:531-8.
314. Brown RO, Forloines-Lynn S, Cross RE, Heizer WD. Chromium deficiency after long-term total parenteral nutrition. *Dig.Dis.Sci.* 1986;31:661-4.
315. Jeejeebhoy KN. Chromium and parenteral nutrition. *J.Trace Elem.Exp.Med.* 1999;12:85-9.
316. Cheng NZ, Zhu XX, Shi HL et al. Follow-up survey of people in China with type 2 diabetes mellitus consuming supplemental chromium. *J.Trace Elem.Exp.Med.* 1999;12:55-60.
317. Anderson RA, Cheng NZ, Bryden NA et al. Elevated intakes of supplemental chromium improve glucose and insulin variables in individuals with type 2 diabetes. *Diabetes* 1997;46:1786-91.
318. Anderson, R. A., Polansky, M. M., Bryden, N. A., and Canary, J. J. Supplemental-chromium effects on glucose, insulin, glucagon, and urinary chromium losses in subjects consuming controlled low- chromium diets. *Am.J.Clin.Nutr.* 54(5), 909-916. 1991.
319. Singh RB, Rastogi SS, Gupta RK, Sharma VK, Singh RG. Can a diet rich in chromium and other minerals modulate blood sugar and blood lipids in noninsulin dependent diabetes mellitus? *9 (3).*1992.157-162. 1992;157-62.
320. Chausmer AB. Zinc, insulin and diabetes. *J Am Coll Nutr* 1998;17:109-15.
321. el-Yazigi A, Hannan N, Raines DA. Effect of diabetic state and related disorders on the urinary excretion of magnesium and zinc in patients. *Diabetes Res* 1993;22:67-75.
322. Blostein-Fujii A, DiSilvestro RA, Frid D, Katz C, Malarkey W. Short-term zinc supplementation in women with non-insulin- dependent diabetes mellitus: Effects on plasma 5'-nucleotidase activities, insulin-like growth factor concentrations, and lipoprotein oxidation rates in vitro. *Am.J.Clin.Nutr.* 1997;66:639-42.
323. Honnorat J, Accominotti M, Broussolle C, Fleuret AC, Vallon JJ, Orgiazzi J. Effects of diabetes type and treatment on zinc status in diabetes mellitus. *Biol Trace Elem.Res* 1992;32:311-6.
324. Brun J-F, Guinrand-Hugret R, Fons C et al. Effects of oral zinc gluconate on glucose effectiveness and insulin sensitivity in humans. *Biol.Trace Elem.Res.* 1995;47:385-92.
325. Lima MD, Cruz T, Pousada JC, Rodrigues LE, Barbosa K, Canguçu V. The effect of magnesium supplementation in increasing doses on the control of type 2 diabetes. *Diabetes Care* 1998;21:682-6.
326. Roffi M, Kanaka C, Mullis PE, Peheim E, Bianchetti MG. Hypermagnesiuria in children with newly diagnosed insulin-dependent diabetes mellitus. *Am.J.Nephrol.* 1994;14:201-6.
327. Khan LA, Alam AMS, Ali L et al. Serum and urinary magnesium in young diabetic subjects in Bangladesh. *Am.J.Clin.Nutr.* 1999;69:70-3.
328. Lowik MR, Van Dokkum W, Kistemaker C, Schaafsma G, Ockhuizen T. Body composition, health status and urinary magnesium excretion among elderly people (Dutch Nutrition Surveillance System). *Magnes.Res.* 1993;6:223-32.
329. Maxwell SRJ, Thomason H, Sandler D et al. Antioxidant status in patients with uncomplicated insulin- dependent and non-insulin-dependent diabetes mellitus. *Eur.J.Clin.Invest.* 1997;27:484-90.
330. Nuttall SL, Dunne F, Kendall MJ, Martin U. Age-independent oxidative stress in elderly patients with non-insulin-dependent diabetes mellitus. *Q.J.Med.* 1999;92:33-8.
331. Cunningham JJ. Micronutrients as nutraceutical interventions in diabetes mellitus. *J.Am.Coll.Nutr.* 1998;17:7-10.
332. Gerster H. Prevention of platelet dysfunction by vitamin E in diabetic atherosclerosis. *Z.Ernahrungswiss.* 1993;32:243-61.
333. Kunisaki M, Umeda F, Inoguchi T, Watanabe J, Nawata H. Effects of vitamin E administration on platelet function in diabetes mellitus. *Diabetes Res* 1990;14:37-42.
334. Tutüncü NB, Bayraktar M, Varli K. Reversal of defective nerve conduction with vitamin E supplementation in type 2 diabetes - A preliminary study. *Diabetes Care* 1998;21:1915-8.
335. Ceriello A, Giugliano D, Quatraro A, Donzella C, Dipalo G, Lefebvre PJ. Vitamin E reduction of protein glycosylation in diabetes. New prospect for prevention of diabetic complications? *Diabetes Care* 1991;14:68-72.
336. Duntas L, Kemmer TP, Vorberg B, Scherbaum W. Administration of d-alpha-tocopherol in patients with insulin-dependent diabetes mellitus.
337. Jain SK, McVie R, Jaramillo JJ, Palmer M, Smith T. Effect of modest vitamin E supplementation on blood glycated hemoglobin and triglyceride levels and red cell indices in type I diabetic patients. *J Am Coll Nutr* 1996;15:458-61.
338. Jain SK, Krueger KS, McVie R, Jaramillo JJ, Palmer M, Smith T. Relationship of blood thromboxane-B2 (TxB2) with lipid peroxides and effect of vitamin E and placebo supplementation on TxB2 and lipid peroxide levels in type 1 diabetic patients. *Diabetes Care* 1998;21:1511-6.
339. Jain SK. Should high-dose vitamin E supplementation be recommended to diabetic patients? *Diabetes Care* 1999;22:1242-4.
340. Som S, Basu S, Mukherjee D et al. Ascorbic acid metabolism in diabetes mellitus. *Metabolism* 1981;30:572-7.
341. Ali SM, Chakraborty SK. Role of plasma ascorbate in diabetic microangiopathy. *Bangladesh.Med Res Counc.Bull.* 1989;15:47-59.
342. Armstrong AM, Chestnutt JE, Gormley MJ, Young IS. The effect of dietary treatment on lipid peroxidation and antioxidant status in newly diagnosed noninsulin dependent diabetes. *Free Radical Biol Med* 1996;21:719-26.
343. Chakraborty SK. Plasma ascorbate status in newly diagnosed diabetics exhibiting retinopathy--a finding that alarms. *Bangladesh.Med Res Counc.Bull.* 1992;18:30-5.

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

344. Sinclair AJ, Taylor PB, Lunec J, Girling AJ, Barnett AH. Low plasma ascorbate levels in patients with type 2 diabetes mellitus consuming adequate dietary vitamin C. *Diabet.Med* 1994;11:893-8.
345. Pecoraro RE, Chen MS. Ascorbic acid metabolism in diabetes mellitus. *Ann.N.Y.Acad.Sci.* 1987;498:248-58.
346. Cunningham JJ, Mearkle PL, Brown RG. Vitamin C: An aldose reductase inhibitor that normalizes erythrocyte sorbitol in insulin-dependent diabetes mellitus. *J.Am.Coll.Nutr.* 1994;13:344-50.
347. Cunningham JJ. The glucose/insulin system and vitamin C: implications in insulin-dependent diabetes mellitus. *J Am Coll Nutr* 1998;17:105-8.
348. McAuliffe AV, Brooks BA, Fisher EJ, Molyneaux LM, Yue DK. Administration of ascorbic acid and an aldose reductase inhibitor (tolrestat) in diabetes: Effect on urinary albumin excretion. *Nephron* 1998;80:277-84.
349. Wang H, Zhang ZB, Wen RR, Chen JW. Experimental and clinical studies on the reduction of erythrocyte sorbitol-glucose ratios by ascorbic acid in diabetes mellitus. *Diabetes Res Clin Pract.* 1995;28:1-8.
350. Eriksson J, Kohvakka A. Magnesium and ascorbic acid supplementation in diabetes mellitus. *Ann.Nutr.Metab.* 1995;39:217-23.
351. Chevion S, Hofmann M, Ziegler R, Chevion M, Nawroth PP. The antioxidant properties of thioctic acid: Characterization by cyclic voltammetry. *Biochem.Mol.Biol.Int.* 1997;41:317-27.
352. Van Dam PS, Bravenboer B. Oxidative stress and antioxidant treatment in diabetic neuropathy. *Neurosci.Res.Comm.* 1997;21:41-8.
353. Haak ES, Usadel KH, Kohleisen M, Yilmaz A, Kusterer K, Haak T. The effect of α -lipoic acid on the neurovascular reflex arc in patients with diabetic neuropathy assessed by capillary microscopy. *Microvasc.Res.* 1999;58:28-34.
354. Ziegler D, Gries FA. Alpha-lipoic acid in the treatment of diabetic peripheral and cardiac autonomic neuropathy. *Diabetes* 1997;46 Suppl 2:S62-S66.
355. Chandra RK. Nutrition and the immune system: An introduction. *Am.J.Clin.Nutr.* 1997;66:460S-3S.
356. Erickson KL, Medina EA, Hubbard NE. Micronutrients and innate immunity. *J.Infect.Dis.* 2000;182:S5-S10.
357. Lesourd BM. Nutrition and immunity in the elderly: Modification of immune responses with nutritional treatments. *Am.J.Clin.Nutr.* 1997;66:478S-84S.
358. Bogden JD, Bendich A, Kemp FW et al. Daily micronutrient supplements enhance delayed-hypersensitivity skin test responses in older people. *Am.J Clin.Nutr.* 1994;60:437-47.
359. Semba RD. Vitamin A, immunity, and infection. *Clin.Infect.Dis.* 1994;19:489-99.
360. Underwood BA. Hypovitaminosis A: International programmatic issues. *J.Nutr.* 1994;124 Suppl.:1467S-72S.
361. Stephensen CB, Alvarez JO, Kohatsu J, Hardmeier R, Kennedy JJ, Jr., Gammon RB, Jr. Vitamin A is excreted in the urine during acute infection. *Am.J.Clin.Nutr.* 1994;60:388-92.
362. Bendich A. Beta-carotene and immune response. *Proc.Nutr.Soc.* 1991;50:263-74.
363. Hughes DA, Wright AJ, Finglas PM et al. The effect of beta-carotene supplementation on the immune function of blood monocytes from healthy male nonsmokers. *J Lab.Clin Med* 1997;129:309-17.
364. Santos, M. S., Gaziano, J. M., Leka, L. S., Beharka, A. A., Hennekens, C. H., and Meydani, S. N. Beta-carotene-induced enhancement of natural killer cell activity in elderly men: an investigation of the role of cytokines. *Am.J.Clin.Nutr.* 1998 68(1), 164-170.
365. Watson RR, Prabhala RH, Plezia PM, Alberts DS, Pike J, Chandra RK. Effect of beta-carotene on lymphocyte subpopulations in elderly humans: evidence for a dose-response relationship. Effect of vitamin and trace element supplementation on immune indices in healthy elderly. *Am.J Clin.Nutr.* 1991;53:90-4.
366. De La Fuente M, Ferrández MD, Burgos MS, Soler A, Prieto A, Miquel J. Immune function in aged women is improved by ingestion of vitamins C and E. *Can.J.Physiol.Pharmacol.* 1998;76:373-80.
367. Hemila H. Vitamin C and common cold incidence: a review of studies with subjects under heavy physical stress. *Int.J Sports Med* 1996;17:379-83.
368. Hemila H. Vitamin C intake and susceptibility to the common cold. *British J.Nutr.* 1997;77:59-72.
369. Hunt C, Chakravorty NK, Annan G, Habibzadeh N, Schorah CJ. The clinical effects of vitamin C supplementation in elderly hospitalised patients with acute respiratory infections. *Int J Vitam.Nutr Res* 1994;64:212-9.
370. Jayachandran M, Panneerselvam C. Cellular immune responses to vitamin C supplementation in ageing humans assessed by the in vitro leucocyte migration inhibition test. *Med.Sci.Res.* 1998;26:227-30.
371. Peters EM, Goetzsche JM, Grobbelaar B, Noakes TD. Vitamin C supplementation reduces the incidence of postrace symptoms of upper-respiratory-tract infection in ultramarathon runners. *Am.J Clin.Nutr.* 1993;57:170-4.
372. Wilson CW, Greene M, Loh HS. The metabolism of supplementary vitamin C during the common cold. *J Clin Pharmacol* 1976;16:19-29.
373. Meydani SN, Beharka AA. Recent developments in vitamin E and immune response. *Nutrition reviews* 1998;56:S49-S58.
374. Serafini M. Dietary vitamin E and T cell-mediated function in the elderly: effectiveness and mechanism of action. *Int.J.Dev.Neurosci.* 2000;18:401-10.
375. Meydani SN, Meydani M, Blumberg JB et al. Vitamin E supplementation and in vivo immune response in healthy elderly subjects. A randomized controlled trial. *JAMA* 1997;277:1380-6.
376. Chavance M, Herbeth B, Fournier C, Janot C, Vernhes G. Vitamin status, immunity and infections in an elderly population. *Eur.J Clin Nutr* 1989;43:827-35.
377. Bates CJ, Pentieva KD, Prentice A, Mansoor MA, Finch S. Plasma pyridoxal phosphate and pyridoxic acid and their relationship to plasma homocysteine in a representative

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

- sample of British men and women aged 65 years and over. *Br.J.Nutr.* 1999;81:191-201.
378. Meydani SN, Ribaya-Mercado JD, Russell RM, Sahyoun N, Morrow FD, Gershoff SN. Vitamin B-6 deficiency impairs interleukin 2 production and lymphocyte proliferation in elderly adults. *Am.J.Clin.Nutr.* 1991;53:1275-80.
 379. Talbott MC, Miller LT, Kerkvliet NI. Pyridoxine supplementation: effect on lymphocyte responses in elderly persons. *Am.J.Clin.Nutr.* 1987;46:659-64.
 380. Folkers K, Morita M, McRee J, Jr. The activities of coenzyme Q10 and vitamin B6 for immune responses. *Biochem.Biophys.Res.Comm.* 1993;193:88-92.
 381. Keen CL, Gershwin ME. Zinc deficiency and immune function. *Annu.Rev.Nutr.* 1990;10:415-31.
 382. Brignola C, Belloli C, De Simone G et al. Zinc supplementation restores plasma concentrations of zinc and thymulin in patients with Crohn's disease. *Aliment.Pharmacol.Ther.* 1993;7:275-80.
 383. Gupta RK, Bhattacharya SK, Sundar S, Kumar K, Kachhawa JS, Sen PC. A correlative study of serum zinc and in vivo cell mediated immune status in rheumatic heart disease. *Acta Cardiol.* 1996;47:297-304.
 384. Sherman AR. Zinc, copper, and iron nutriture and immunity. *J.Nutr.* 1992;122:604-9.
 385. Mei W, Dong ZM, Liao BL, Xu HB. Study of immune function of cancer patients influenced by supplemental zinc or selenium-zinc combination. *Biol.Trace Elem.Res.* 1991;28:11-9.
 386. Shankar AH, Prasad AS. Zinc and immune function: the biological basis of altered resistance to infection. *Am.J.Clin.Nutr.* 1998;68:447S-63S.
 387. Wellinghausen N, Kirchner H, Rink L. The immunobiology of zinc. *Immunol.Today* 1997;18:519-21.
 388. Prasad AS. Zinc and immunity. *Mol.Cell.Biochem.* 1998;188:63-9.
 389. Mazzotta MY. Nutrition and wound healing. *J.Am.Podiatr.Med.Assoc.* 1994;84:456-62.
 390. Sun E, Xu H, Liu Q, Zhou J, Zuo P, Wang J. The mechanism for the effect of selenium supplementation on immunity. *Biol.Trace Elem.Res.* 1995;48:231-8.
 391. Roy M, Kiremidjian-Schumacher L, Wishe HI, Cohen MW, Stotzky G. Supplementation with selenium restores age-related decline in immune cell function. *Proc.Soc.Exp.Biol.Med.* 1995;209:369-75.
 392. Rayman MP. The importance of selenium to human health. *Lancet* 2000;356:233-41.
 393. Taylor EW. Selenium and cellular immunity - Evidence that selenoproteins may be encoded in the +1 reading frame overlapping the human CD4, CD8, and HLA-DR genes. *Biol.Trace Elem.Res.* 1995;49:85-95.
 394. Levander OA, Beck MA. Selenium and viral virulence. *Br.Med.Bull.* 1999;55:528-33.
 395. Beck MA. Nutritionally induced oxidative stress: effect on viral disease. *Am.J.Clin.Nutr.* 2000;71:1676S-9S.
 396. Forceville X, Vitoux D, Gauzit R, Combes A, Lahilaire P, Chappuis P. Selenium, systemic immune response syndrome, sepsis, and outcome in critically ill patients. *Crit.Care Med.* 1998;26:1536-44.
 397. Girodon F, Lombard M, Galan P et al. Effect of micronutrient supplementation on infection in institutionalized elderly subjects: A controlled trial. *Ann.Nutr.Metab.* 1997;41:98-107.
 398. Goldbloom R, Battista RN, Anderson G et al. Periodic health examination, 1994 update: 3. Primary and secondary prevention of neural tube defects. *Can.Med.Assoc.J.* 1994;151:159-66.
 399. Daly S, Mills JL, Molloy AM et al. Minimum effective dose of folic acid for food fortification to prevent neural-tube defects. *Lancet* 1997;350:1666-9.
 400. Berry RJ, Li Z, Erickson JD et al. Prevention of neural-tube defects with folic acid in China. *N.Engl.J.Med.* 1999;341:1485-90.
 401. Werler MM, Hayes C, Louik C, Shapiro S, Mitchell AA. Multivitamin supplementation and risk of birth defects. *Am.J.Epidemiol.* 1999;150:675-82.
 402. Seddon JM, Ajani UA, Sperduto RD et al. Dietary carotenoids, vitamins A, C, and E, and advanced age-related macular degeneration. *Eye Disease Case-Control Study Group. JAMA* 1994;272:1413-20.
 403. Berendschot TJJM, Goldbohm RA, Klöpping WAA, Van de Kraats J, Van Norel J, Van Norren D. Influence of lutein supplementation on macular pigment, assessed with two objective techniques. *Invest.Ophthalmol.Vis.Sci.* 2000;41:3322-6.
 404. Bone RA, Landrum JT, Dixon Z, Chen Y, Llerena CM. Lutein and zeaxanthin in the eyes, serum and diet of human subjects. *Exp.Eye Res.* 2000;71:239-45.
 405. Brown L, Rimm EB, Seddon JM et al. A prospective study of carotenoid intake and risk of cataract extraction in US men. *Am.J.Clin.Nutr.* 1999;70:517-24.
 406. Chasan-Taber L, Willett WC, Seddon JM et al. A prospective study of carotenoid and vitamin A intakes and risk of cataract extraction in US women. *Am.J.Clin.Nutr.* 1999;70:509-16.
 407. Moeller SM, Jacques PF, Blumberg JB. The potential role of dietary xanthophylls in cataract and age-related macular degeneration. *J.Am.Coll.Nutr.* 2000;19:522S-7S.
 408. Pratt S. Dietary prevention of age-related macular degeneration. *J Am Optom.Assoc.* 1999;70:39-47.
 409. Yeum KJ, Shang F, Schalch W, Russell RM, Taylor A. Fat-soluble nutrient concentrations in different layers of human cataractous lens. *Curr.Eye Res.* 1999;19:502-5.
 410. Gerster H. Antioxidant vitamins in cataract prevention. *Z.Ernahrungswiss.* 1989;28:56-75.
 411. Jacques PF, Chylack LTJ. Epidemiologic evidence of a role for the antioxidant vitamins and carotenoids in cataract prevention. *Am.J.Clin.Nutr.* 1991;53:352S-5S.
 412. Belda JI, Romá J, Vilela C et al. Serum vitamin E levels negatively correlate with severity of age-related macular degeneration. *Mech Ageing Dev* 1999;107:159-64.
 413. Delcourt C, Cristol JP, Tessier F et al. Age-related macular degeneration and antioxidant status in the POLA study. *Arch.Ophthalmol.* 1999;117:1384-90.

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414. Lyle BJ, Mares-Perlman JA, Klein BE et al. Serum carotenoids and tocopherols and incidence of age-related nuclear cataract. *Am.J.Clin.Nutr.* 1999;69:272-7.
415. Seth RK, Kharb S. Protective function of alpha-tocopherol against the process of cataractogenesis in humans. *Ann.Nutr.Metab.* 1999;43:286-9.
416. Hathcock, J. N. *Vitamin and Mineral Safety.* 1997. Washington, DC, Council for Responsible Nutrition.
417. Food and Nutrition Board and Institute of Medicine. *Dietary Reference Intakes for Vitamin C, Vitamin E, Selenium and Carotenoids.* (Advance Copy). 2000. Washington, D.C., National Academy Press.
418. Food and Nutrition Board and Institute of Medicine. *Dietary Reference Intakes: Thiamin, Riboflavin, Niacin, Vitamin B-6, Folate, Vitamin B-12, Pantothenic Acid, Biotin, and Choline.* Prepublication Copy. 1998. Washington, D.C., National Academy Press.
419. Thomas JA. Drug-nutrient interactions. *Nutr Rev* 1995;53:271-82.
420. Matsui MS, Rozovski SJ. Drug-nutrient interaction. *Clin.Ther.* 1997;4:423-40.
421. Andersen P, Godal HC. Predictable reduction in anticoagulant activity of warfarin by small amounts of vitamin K. *Acta Med Scand* 1975;198:269-70.
422. Karlson, B., Leijd, B., and Hellstrom, K. On the influence of vitamin K-rich vegetables and wine on the effectiveness of warfarin treatment. *Acta Med Scand* 220(4), 347-350. 1986.
423. Booth SL, Charnley JM, Sadowski JA, Saltzman E, Bovill EG, Cushman M. Dietary vitamin K-1 and stability of oral anticoagulation: Proposal of a diet with constant vitamin K-1 content. *Thrombosis and Haemostasis* 1997;77:504-9.
424. Sorano GG, Biondi G, Conti M, Mameli G, Licheri D, Marongiu F. Controlled vitamin K content diet for improving the management of poorly controlled anticoagulated patients: a clinical practice proposal. *Haemostasis* 1993;23:77-8.

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