BMJ Open  Effect of polyphenol compounds on Helicobacter pylori eradication: a systematic review with meta-analysis

Qiuxiang Wang , Chengjiao Yao, Yilin Li, Lihong Luo, Fengjiao Xie, Qin Xiong, Peimin Feng

ABSTRACT

Objectives Polyphenol compounds are classified as organic compounds with phenolic units exhibiting a variety of biological functions. This meta-analysis aims to assess the efficacy and safety of polyphenol compounds (curcumin, cranberry, garlic, liquorice and broccoli) in eradicating Helicobacter pylori.

Design Systematic review and meta-analysis.

Methods Literature searches were conducted on PubMed, Embase, The Cochrane Library, Web of Science, Medline, Chinese National Knowledge Infrastructure database, Chinese Scientific Journal Database and Wan Fang database from inception to January 2022. All randomised controlled trials comparing polyphenol compounds with the placebo or used as an adjunct treatment are included in this meta-analysis. The treatment effect for dichotomous outcomes was assessed using risk ratio (RR), while for continuous outcomes, mean differences both with 95% CIs, were used. Subgroup analyses were carried out for different treatment schemes and polyphenol compound species.

Results 12 trials were included in the meta-analysis. The total eradication rate of H. pylori in the polyphenol compounds group was higher than in the group without polyphenol compounds. Statistical significance was also observed (RR 1.19, 95% CI 1.03 to 1.38, p=0.02). The most frequent adverse effects of polyphenol compounds included diarrhoea, headache and vomiting. However, there were no differences regarding side effects between the two groups (RR 1.47, 95% CI 0.83 to 2.58, p=0.18).

In subgroup analyses, the H. pylori eradication rate regimens with polyphenols therapy was superior to that of regimens without polyphenols therapy in the polyphenols versus placebo subgroup (RR 4.23, 95% CI 1.38 to 12.95, p=0.01), polyphenols plus triple therapy versus triple therapy subgroup (RR 1.11, 95% CI 1.01 to 1.22, p=0.03).

Conclusion Polyphenol compounds can improve H. pylori eradication rates. Polyphenol compounds plus standard triple therapy can significantly improve the eradication. However, no evidence of a higher incidence of side effects could be found.

PROSPERO registration number CRD42022307477.

INTRODUCTION

Helicobacter pylori has gained widespread attention for nearly 40 years since its identification by Marshall and Warren in 1984. H. pylori is a spiral-shaped Gram-negative, microaerophilic bacterium that colonises the gastric mucosa. H. pylori is usually acquired in childhood and can last a lifetime. It was first explicitly formulated in the Kyoto Global Consensus Report that H. pylori gastritis should be considered an infectious disease regardless of whether the affected individual has any symptoms, complications or subsequent illnesses. H. pylori has been classified as a group 1 carcinogen by the International Agency for Research on Cancer. H. pylori infection is considered the leading cause of gastric cancer.
More than half the world’s population is infected with *H. pylori*. The prevalence of *H. pylori* varies significantly between regions and countries. Africa has the highest prevalence (79.1%), followed by Latin America and the Caribbean (63.4%) and Asia (54.7%). In contrast, the prevalence is lowest in Northern America (37.1%) and Oceania (24.4%). The global prevalence of *H. pylori* is similar between genders, with 42.7% in women and 46.3% in men, and approximately 20% of those infected will develop the disease. The pooled *H. pylori* prevalence was 44.2% in mainland China, with an estimated 589 million people infected. Furthermore, according to recent epidemiological data, the recurrence rate of *H. pylori* has increased over the past decade, and it remains a complex global public health problem that places a significant socioeconomic burden on the healthcare system.

The recurrence rate of *H. pylori* increases with time after eradication and varies by region, gender and eradication methods. Therefore, it is critical to identify an effective regimen in this era of increasing antibiotic resistance. New approaches, such as polyphenol compounds, are being tested to enhance *H. pylori* eradication rates.

Polyphenol compounds are classified as organic compounds having phenolic units that display an array of biological functions. Polyphenol substances (eg, curcumin, cranberry, garlic, liquorice and broccoli) with potent antioxidant and anti-inflammatory properties can modulate key signalling molecules of enormous pharmacological interest. Polyphenols may contribute to gastrointestinal health, as these bioactive compounds can inhibit *H. pylori* proliferation. Several studies indicate that these polyphenol compounds positively affect *H. pylori* eradication. However, several experimental and clinical studies have shown different results. There are no known meta-analyses concerning the effects of polyphenol compounds on *H. pylori* infection. Therefore, we performed a meta-analysis of randomised controlled trials (RCTs) to evaluate the effect of polyphenol compounds on the eradication rate of *H. pylori* infection.

**Materials and Methods**

**Search strategy**

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2020 guidelines and was registered in PROSPERO. A systematic search was performed in the following eight databases with a restriction of time from inception to January 2022 to filter the eligible studies: PubMed, Embase, The Cochrane Library, Web of Science, Medline, Chinese National Knowledge Infrastructure database (CNKI), Chinese Scientific Journal Database (VIP) and Wan Fang database. The following search keywords were used: [Helicobacter pylori] or [Helicobacter nemestrinae] or [Campylobacter pylori] or [Campylobacter pylori subsp. pylori] or [Campylobacter pyloriidis]; [Polyphenols] or [Curcumin] or [Vaccinium macrocarpon] or [Garlic] or [Liquorice] or [Glycyrrhiza] or [Brassica]; and [Randomised controlled clinical trials] or [Randomised placebo-controlled trials] or [Randomised clinical trials] or [Randomised clinical trials, parallel group] or [Randomised clinical trials, cross-over] or [Randomised clinical trials, parallel group, placebo-controlled] or [Randomised controlled clinical trials] or [Randomised Controlled Clinical Trials] or [Randomised placebo controlled trials] or [Randomised clinical trials, parallel group] or [Randomised clinical trials, cross-over] or [Randomised clinical trials, parallel group, placebo-controlled] or [Randomised controlled clinical trials].

**Box 1 Search strategy in PubMed database**

<table>
<thead>
<tr>
<th>Search items</th>
<th>PubMed criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 (“Polyphenols”[(Mesh)]) OR (Polyphenol) OR (Provinols)</td>
<td>#1 (“Polyphenols”[(Mesh)]) OR (Polyphenol) OR (Provinols)</td>
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<tr>
<td>#2 (“Curcumin”[(Mesh)]) OR (((1’,6-Heptadiene-3,5-dione, 1,7-bis(4 -hydroxy-3-methoxyphenyl)-(E,E) )) OR (Turmeric Yellow) OR (Yellow, Turmeric) ) OR (Curcumin Phytoosome) OR (Phytosome, Curcumin) OR (Diferuloylmethane) OR (Mervia)</td>
<td>#2 (“Curcumin”[(Mesh)]) OR (((1’,6-Heptadiene-3,5-dione, 1,7-bis(4 -hydroxy-3-methoxyphenyl)-(E,E) )) OR (Turmeric Yellow) OR (Yellow, Turmeric) ) OR (Curcumin Phytoosome) OR (Phytosome, Curcumin) OR (Diferuloylmethane) OR (Mervia)</td>
</tr>
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<td>#3 (&quot;Vaccinium macrocarpon&quot;[(Mesh)]) OR (((Vaccinium macrocarpons) OR (macarpon, Vaccinnium)) OR ( Cranberry)) OR ( Cranberries)</td>
<td>#3 (&quot;Vaccinium macrocarpon&quot;[(Mesh)]) OR (((Vaccinium macrocarpons) OR (macarpon, Vaccinnium)) OR ( Cranberry)) OR ( Cranberries)</td>
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<tr>
<td>#5 (&quot;Glycyrrhiza&quot;[(Mesh)]) OR (((Liquorice) OR (Liquorices)) OR (Licorice) OR (Licorices) OR (Glycyrrhiza glabra)</td>
<td>#5 (&quot;Glycyrrhiza&quot;[(Mesh)]) OR (((Liquorice) OR (Liquorices)) OR (Licorice) OR (Licorices) OR (Glycyrrhiza glabra)</td>
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<td>#6 (&quot;Brassica&quot;[(Mesh)]) OR (((Brussel Sprout) OR (Collard Green) OR (Collard Greens)) OR (Kale) OR (Cauliflower)) OR (Broccoli) OR (Cabbage) OR (Cabbages)</td>
<td>#6 (&quot;Brassica&quot;[(Mesh)]) OR (((Brussel Sprout) OR (Collard Green) OR (Collard Greens)) OR (Kale) OR (Cauliflower)) OR (Broccoli) OR (Cabbage) OR (Cabbages)</td>
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<td>#7 #1 or #2 or #3 #4 or #5 or #6</td>
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<td>#8 (&quot;Helicobacter pylori&quot;[(Mesh)]) OR (Heliocobacter nemestinae OR (Campylobacter pylori) OR (Campylobacter pylori subsp. pylori) OR (Campylobacter pyloriidis)</td>
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<td>#9 (&quot;RandomizedRandomised Controlled Trial&quot; [(Publication Type)]) OR (Clinical Trials, RandomizedRandomised[(Title/Abstract)]) OR (Trials, RandomizedRandomised[(Clinical Title/Abstract)]) OR (Controlled Clinical Trials, RandomizedRandomised[(Title/Abstract)])</td>
<td>#9 (&quot;RandomizedRandomised Controlled Trial&quot; [(Publication Type)]) OR (Clinical Trials, RandomizedRandomised[(Title/Abstract)]) OR (Trials, RandomizedRandomised[(Clinical Title/Abstract)]) OR (Controlled Clinical Trials, RandomizedRandomised[(Title/Abstract)])</td>
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<td>#10 #7 and #8 and #9</td>
<td>#10 #7 and #8 and #9</td>
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</table>

**Study selection (inclusion and exclusion criteria)**

Two independent reviewers (QW and CY) reviewed the initial search results. The following criteria were used for literature selection: (1) articles published in English or Chinese; (2) adults infected with *H. pylori* with/without *H. pylori*-related disease, including functional dyspepsia, gastritis and ulcers. The diagnosis of *H. pylori* infection was based on positive histology, rapid urease tests, urease breath tests or *H. pylori* stool antigen test; (3) articles that assessed the efficacy of polyphenol compounds in *H. pylori* eradication; (4) the intervention of the treatment group comprised of polyphenol compounds alone or in combination with *H. pylori* eradication therapy. The control group received just the placebo without polyphenol compounds, or *H. pylori* eradication therapy; (5) the eradication rates and/or side effects data were available; (6) the study design consisted of RCTs; (7) the polyphenol compounds were restricted to curcumin, cranberry, garlic, liquorice and broccoli. The exclusion criteria included: (1) duplicate articles or evaluation of the same samples; (2) articles published as observational studies, narrative reviews, basic researches, meta-analyses, retrospective studies, case reports or conference presentations; (3) use of oral antibiotics and/or proton pump inhibitors (PPIs) and/ or H2-antagonists during the 2 weeks before intake of the...
study product; (4) extraction of polyphenols from other sources, such as tea, coffee, cocoa, wine, etc.

**Data extraction**

Two reviewers (FX and QX) independently extracted data from the included studies using a predesigned data extraction tool. Any disagreements were resolved by negotiation and discussion. Any additional disagreements were arbitrated by a third reviewer (PF). The following information was extracted from each included study: the first author’s name, publication year, location, number of patients, diagnostic methods for testing *H. pylori* infection before enrolling and after completing the study, polyphenol compounds group regimen, control group regimen, the time test for *H. pylori* eradication, eradication rate as the primary outcome and side effect rate as the secondary outcome.

**Quality appraisal**

Two authors (LL and YL) independently evaluated the risk of bias of each included article using the Cochrane Handbook for Systematic Reviews of Interventions. The methodologic quality was evaluated based on the following seven aspects: random sequence generation, allocation concealment, binding of participants and personnel, binding of outcome assessments, incomplete outcome data, selective reporting and other biases. The risks were classified as low, high or unclear using a graphical representation. The quality assessment of each paper is shown in table 1.

**Statistical analysis**

Meta-analysis and statistical analysis were performed using RevMan software (V.5.3.0). The results were presented using the risk ratio (RR) with 95% CIs for dichotomous data. The mean difference with 95% CIs was presented using the risk ratio (RR) with 95% CIs for polyphenol compounds group regimen, control group regimen, the time test for *H. pylori* eradication, eradication rate as the primary outcome and side effect rate as the secondary outcome.

**Table 1** Risk of bias of the included randomised controlled trials

<table>
<thead>
<tr>
<th>Author/reference</th>
<th>Random sequence generation</th>
<th>Allocation concealment</th>
<th>Blinding of participants and personnel</th>
<th>Blinding of outcome assessment</th>
<th>Incomplete outcome data</th>
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<th>Other bias</th>
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<td>Low risk</td>
<td>Unclear risk</td>
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</table>

was considered statistically significant. Heterogeneity among studies was evaluated via χ² tests and the inconsistency statistic. I²>50% and/or p<0.1 indicated significant heterogeneity. The fixed-effects model (Mantel-Haenszel) was used to analyse the data if there was no heterogeneity, while the random effects model was used if I²>50%. Subgroup analyses were conducted based on different treatment schemes and polyphenol compound species.

**Patient and public involvement**

No patient was involved.

**RESULTS**

**Study selection and study characteristics**

The literature search yielded 1178 articles, of which 569 were excluded as duplicates and 492 by title or abstract. The full texts of the remaining 117 articles were reviewed. Of these articles, 65 were unrelated, and 37 were basic research, systematic reviews or meta-analyses. One trial was excluded because it was conducted on children and two studies were not RCTs. A total of 12 RCTs with 1251 participants (624 from the polyphenol compounds group and 627 from the control group) were finally included. A flowchart of the article screening and selection processes is shown in figure 1. Eight studies<sup>27–34</sup> were conducted in Iran, two<sup>18 35</sup> in China, and the remaining studies were conducted in Israel<sup>36</sup> and India.<sup>37</sup> These studies were published between 2005 and 2021. All the studies were RCTs. Of the 12 studies, two studies<sup>27 28</sup> evaluated the efficacy of curcumin in eradicating *H. pylori*, four studies<sup>18 35 36</sup> evaluated the efficacy of cranberry, four studies<sup>30–32 37</sup> assessed the efficacy of liquorice, one study<sup>34</sup> evaluated the efficacy of garlic, and one study<sup>33</sup> assessed the efficacy of broccoli in eradicating *H. pylori*. The characteristics of each included study are summarised in table 2.
Risk of bias
The Cochrane risk of bias assessment tool was used to evaluate the quality of the included studies.25 The methodological quality of the included trials was generally poor. In random sequence generation, three trials33 35 37 used proper generation methods with a low risk of bias, and the random number sequences were generated by either computer software or a sealed envelope. However, nine trials18 27–32 34 36 did not clearly describe the randomisation procedure. Methods for double-blind were described by seven of the studies.18 28 31 32 35–37 One study33 described allocation concealment methods as a sealed envelope. Other studies have not described allocation concealment methods. Complete outcome data were reported by 12 studies. All studies had a low risk of selective reporting bias. All studies had an unclear risk of other biases.

RESULTS
Trial description
Among the 12 enrolled studies, three studies18 35 37 compared the effects of polyphenols with placebo on the eradication rate of H. pylori infection; six studies27–30 33 36 compared the effects of polyphenols along with triple therapy on the eradication rate of H. pylori infection; two studies31 32 compared the effects of polyphenol plus triple therapy with bismuth triple therapy; one study34 compared the effects of polyphenols plus quadruple regimen with quadruple regimen plus placebo on the eradication rate of H. pylori infection.

Primary outcomes
H. pylori eradication rate
Among the total cases, 624 patients were placed in the experimental group and 627 in the control group (figure 2). The Mantel-Haenszel random-effects model was used due to high heterogeneity ($I^2=68\%$, $p<0.01$). For therapy with and without polyphenol compounds, the crude H. pylori eradication rate was 62.7% and 50.1%, respectively. The eradication efficacy of treatment with polyphenol compounds was higher than treatment without polyphenol compounds. Statistical significance was also observed (RR 1.19, 95% CI 1.03 to 1.38, $p=0.02$).

Secondary outcomes
Side effects
Among the 12 studies, three studies28 32 37 provided information regarding side effects. During one study,32 no

Figure 1 Flow diagram of search method and study selection. CNKI, China National Knowledge Infrastructure; VIP, Chinese Scientific Journal database.
side effects or interactions (such as severe hypertension, muscular weakness or diarrhoea) were reported that led to treatment discontinuation. The side effect rates were observed in two RCTs, including 160 patients. The most frequent adverse reactions were diarrhoea, headache and vomiting, followed by mild body temperature, nausea, throat pain and mild cold and cough. The side effect rate in the treatment group was 27.5%, while in the control group, it was 18.8%. There was no significant difference between these two groups (RR 1.47, 95% CI 0.83 to 2.58, p=0.18) (figure 3).

**Subgroup analysis**

**Subgroup analysis of different treatment schemes**

In the polyphenols versus placebo subgroup, the crude *H. pylori* eradication rate was 24.1% for polyphenols and 5.2% for placebo. The crude *H. pylori* eradication rate in the polyphenols plus triple therapy versus triple therapy

<table>
<thead>
<tr>
<th>Author/reference</th>
<th>Country</th>
<th>Number of patients (T/C)</th>
<th>Test for confirming <em>H. pylori</em> infection</th>
<th>Polyphenol compounds group</th>
<th>Control group</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judaki et al 27</td>
<td>Iran</td>
<td>50/50</td>
<td>14C-UBT HpSAg</td>
<td>Curcumin 700 mg tid 4w plus control group therapy</td>
<td>Omeprazole 20 mg, bid, 1w amoxicillin 1 g, bid, 1w metronidazole 800 mg, bid, 1w</td>
<td>Eradication of <em>H. pylori</em></td>
</tr>
<tr>
<td>Khonche et al 28</td>
<td>Iran</td>
<td>30/30</td>
<td>UBT</td>
<td>Clarithromycin 500 mg, bid, 2w amoxicillin 1 g, bid, 2w pantoprazole 40 mg, bid, 2w curcumin 500 mg, qd, 2w</td>
<td>Clarithromycin 500 mg, bid, 2w amoxicillin 1 g, bid, 2w pantoprazole 40 mg, bid, 2w placebo qd, 2w</td>
<td>Eradication of <em>H. pylori</em> side effects</td>
</tr>
<tr>
<td>Shmuely et al 29</td>
<td>Israel</td>
<td>89/88</td>
<td>13C-UBT</td>
<td>Omeprazole 20 mg, bid, 1w amoxicillin 1 g, bid, 1w clarithromycin 500 mg, bid, 1w cranberry juice 250 mL, bid, 2w</td>
<td>Omeprazole 20 mg, bid, 1w amoxicillin 1 g, bid, 1w clarithromycin 500 mg, bid, 1w placebo beverage 250 mL, bid, 2w</td>
<td>Eradication of <em>H. pylori</em></td>
</tr>
<tr>
<td>Zhang et al 30</td>
<td>China</td>
<td>97/92</td>
<td>13C-UBT</td>
<td>Cranberry juice, 250 mL, bid, 90d</td>
<td>Placebo, 250 mL, bid, 90d</td>
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<td>Li et al 31</td>
<td>China</td>
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<td>13C-UBT</td>
<td>Cranberry juice 240 mL, bid, 8w</td>
<td>Placebo juice 240 mL, bid, 8w</td>
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<td>Iran</td>
<td>100/100</td>
<td>13C-UBT Histology</td>
<td>Cranberry capsules, 500 mg, bid 2w plus control group therapy</td>
<td>Lansoprazole 30 mg, bid, 2w amoxicillin 1 g, bid, 2w clarithromycin 500 mg, bid, 2w</td>
<td>Eradication of <em>H. pylori</em></td>
</tr>
<tr>
<td>Puram et al 33</td>
<td>India</td>
<td>50/50</td>
<td>13C-UBT HpSAg</td>
<td>GutGard 150 mg, qd, 60d</td>
<td>Placebo, 150 mg, qd, 60d</td>
<td>Eradication of <em>H. pylori</em> side effects</td>
</tr>
<tr>
<td>Hajiaghamohammadi et al 34</td>
<td>Iran</td>
<td>54/56</td>
<td>HpSAg</td>
<td>Liquorice 380 mg, bid 2w plus control group therapy</td>
<td>Clarithromycin 500 mg, bid, 2w amoxicillin 1 g, bid, 2w oneprazole 20 mg, bid, 2w plus oneprazole 20 mg, qd, 4w</td>
<td>Eradication of <em>H. pylori</em></td>
</tr>
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<td>Rahnama et al 35</td>
<td>Iran</td>
<td>20/20</td>
<td>UBT</td>
<td>Amoxicillin 500 mg, tid, 15d metronidazole 250 mg, qd, 15d oneprazole 20 mg, bid, 30 d liquorice 250 mg, tid 30d</td>
<td>Amoxicillin 500 mg, tid, 15d metronidazole 250 mg, qd, 15d oneprazole 20 mg, bid, 30 d bismuth sub nitrate 500 mg, tid, 30 d</td>
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</tr>
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<td>Momeni et al 36</td>
<td>Iran</td>
<td>30/30</td>
<td>UBT</td>
<td>Metronidazole 500 mg bid 2w amoxicillin 1 g, bid, 2w oneprazole 20 mg, bid, 2w liquorice 380 mg, bid, 2w</td>
<td>Metronidazole 500 mg, bid, 2w amoxicillin 1 g, bid, 2w oneprazole 20 mg, bid, 2w bismuth sub salicylate, 262 mg, bid 2w</td>
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<tr>
<td>Miran et al 37</td>
<td>Iran</td>
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<td>HpSAg</td>
<td>Broccoli sprouts powder 6 g, qd, 4w plus control group therapy</td>
<td>Oneprazole 20 mg, bid, 2w clarithromycin 500 mg, bid, 2w amoxicillin 1 g, bid, 2w</td>
<td>Eradication of <em>H. pylori</em></td>
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<td>Hekmatdoost et al 38</td>
<td>Iran</td>
<td>15/15</td>
<td>UBT</td>
<td>Garlic powder 4 g, qd, 8w oneprazole 20 mg, bid, 2w amoxicillin 1 g, bid, 2w Bismuth 1.5 g bid, 2w metronidazole 500 mg, bid, 2w</td>
<td>Placebo 4 g, qd, 8w oneprazole 20 mg, bid, 2w amoxicillin 1 g, bid, 2w Bismuth 1.5 g bid, 2w metronidazole 500 mg, bid, 2w</td>
<td>Eradication of <em>H. pylori</em></td>
</tr>
</tbody>
</table>

bid, twice a day; C, control group; HpSAg, stool antigen test; qd, once a day; qd, four times a day; T, treatment group; tid, three times a day; UBT, urease breath test; w, week.
subgroup was 85.3% and 75.9%, respectively. The crude 
\textit{H. pylori} eradication rate in the polyphenols plus triple 
therapy versus bismuth triple therapy subgroups was 62% 
and 50%, respectively. In the polyphenols plus quadruple 
regimen versus quadruple regimen subgroups, the crude 
\textit{H. pylori} eradication rate was 86.7% and 73.3%, 
respectively.

Figure 4 shows that the \textit{H. pylori} eradication rate of regi-
mens with polyphenols therapy was superior to that of 
regimens without polyphenol therapy in the polyphenols 
versus placebo subgroup (RR: 4.23, 95% CI 1.38 to 12.95, 
p=0.01) and the polyphenols plus triple therapy versus 
triple therapy subgroup (RR 1.11, 95% CI 1.01 to 1.22, 
p=0.03). No difference was observed between the poly-
phenols plus therapy and bismuth triple therapy 
subgroups (RR 1.23, 95% CI 0.87 to 1.73, p=0.25). In the 
polyphenols plus quadruple regimen versus quadruple 
regimen subgroups, no difference was observed between 
the two groups (RR 1.18, 95% CI 0.82 to 1.70, p=0.37).

Subgroup analysis of different kinds of polyphenols

The curcumin therapy subgroup consisted of two 
studies.27 28 The cranberry therapy subgroup included 
four studies.18 29 35 36 The liquorice therapy subgroup 
include four studies,30–32 while one study33 was enrolled 
as the garlic therapy subgroup and one33 as the broccoli 
therapy subgroup.

Figure 5 displays that the crude \textit{H. pylori} eradication 
rate in the curcumin subgroup was 81.3% for the treat-
ment group and 73.8% for the control group. The crude 
\textit{H. pylori} eradication rate in the cranberry subgroup was 
54.4% and 45.4% for the treatment and control groups, 
respectively. The crude \textit{H. pylori} eradication rate in the 
liquorice subgroup was 64.9% and 39.1% for the treat-
ant group and control groups, respectively. The crude \textit{H. pylori} eradication rate in the garlic subgroup was 86.7% 
and 73.3% for the treatment and control groups, respec-
tively. The crude \textit{H. pylori} eradication rate in the broccoi 
subgroup was 91.7% for the treatment group and 89.3% 
for the control group. However, there was no statistical 
significance in the subgroup analysis based on different 
polyphenol compounds (curcumin: (RR 1.11, 95% CI 
0.94 to 1.31, p=0.21) cranberry: (RR 1.24, 95% CI 0.94 
to 1.64, p=0.13) liquorice: (RR 1.57, 95% CI 0.89 to 2.78, 
p=0.12) garlic: (RR 1.18, 95% CI 0.82 to 1.70, p=0.37) brocoli: (RR 1.03, 95% CI 0.86 to 1.22, p=0.77)).

Sensitivity analysis

By removing one study at a time, none of the studies 
significantly altered the pooled risk of the \textit{H. pylori} eradica-
tion rates, indicating the results of this study were 
reliable.

Publication bias

The funnel plot obtained by an intentional analysis of 
eradication rates revealed a slightly asymmetrical distri-
bution (figure 6). Visual inspection of the funnel plot 
suggested that publication bias existed.

DISCUSSION

Summary of evidence

We found that the eradication rate of \textit{H. pylori} was higher 
for eradication therapy with polyphenol compounds than 
without polyphenol compounds. These results showed 
a possible beneficial effect of polyphenol compounds 
on eradicating \textit{H.pylori}. Furthermore, no evidence for 
an increased rate of side effects could be found. In 
the subgroup analysis, the three studies18 35 36 involving 
polyphenols showed a higher eradication rate than the
placebo group. The six studies with polyphenols plus triple therapy showed a higher eradication than the triple therapy group. However, there were no differences between the polyphenols plus triple therapy and bismuth triple therapy subgroups, nor between the polyphenols plus quadruple regimen and the quadruple regimen subgroups. Finally, we analysed the efficacy of eradication rates according to the polyphenol compound species. However, no significant differences existed between these five subgroups.

The harmfulness of *H. pylori* and the current treatment status

Infection with *H. pylori* is a major pathogenic factor for superficial gastritis, chronic atrophic gastritis, duodenal or gastric ulcers and gastric mucosa-associated lymphoid tissue lymphoma. It has also been linked with several extra-digestive diseases such as atherosclerosis, coronary heart disease, iron deficiency anaemia, idiopathic thrombocytopenic purpura, vitamin B12 deficiency, non-alcoholic fatty liver disease, metabolic syndrome, diabetes mellitus, cerebrovascular disease, Alzheimer’s disease, Parkinson’s disease, childhood asthma, chronic obstructive pulmonary disease, chronic urticaria, rosacea and osteoporosis. *H. pylori* eradication is required for managing *H. pylori*-related complications.

The efficacy of standard 1-week triple therapy containing clarithromycin and either metronidazole or amoxicillin combined with a PPI has decreased dramatically, with eradication rates as low as 50%–70%. Antibiotic resistance and patient compliance are the major causes of this decline. Bismuth-containing quadruple therapy is now recommended as the main empirical therapy in regions with high clarithromycin and metronidazole resistance (>15%). Concomitant, sequential and hybrid therapies are also recommended for treating *H. pylori* infection. However, there are currently few, if any, regimens consistently achieve eradication rates exceeding 90%.

Our research results indicate that polyphenol compounds can significantly improve *H. pylori* eradication; it might be more effective during polyphenol treatment combined with standard triple therapy. Our findings support that polyphenol compounds can be used as a promising adjuvant therapy to eradicate *H. pylori*, which is of great clinical importance in the era of antibiotic resistance.

Other studies supporting the findings

Polyphenols possess numerous pharmacological and therapeutic properties, including antioxidant and anti-inflammatory activities. The main attribute of polyphenols and their metabolites is their antioxidant action by targeting immune cells and activating different signaling pathways that modify interleukins, cyclooxygenase, nitric oxide synthase and other inflammatory responses. The yellow pigment curcumin (diferuloylmethane) is a key poly-phenolic molecule found in turmeric root.
Curcumin exhibits anti-inflammatory, antioxidant, anticancer, antiviral and neurotrophic activities. Its effects on *H. pylori* infection have been repeatedly confirmed in animal and human models. It has been demonstrated in animal experiments that curcumin treatment exhibited a significant anti-inflammatory effect in *H. pylori*-infected gastric mucosa. Several studies have shown that cranberry juice constituents inhibit the adhesion of numerous microbial pathogens, including *H. pylori*, *E. coli*, oral bacteria and influenza virus. Mechanisms of cranberry’s suppression of *H. pylori* may be due to phenolic compounds found in the fruit. In a clinical trial conducted on colonised Chinese adults, cranberry juice eradicated *H. pylori* in 14.4% of subjects. Cranberry extract inhibited *H. pylori* proliferation in vitro, suggesting that polyphenols are responsible for this action. The morphological analysis revealed that cranberry induces *H. pylori* to develop a coccoid form, inhibiting its growth.

Several studies have shown that extracts from raw garlic or garlic powder tablets maintain in vitro activity against *H. pylori*. Moreover, licorice (liquorice or sweet wood) has been shown to have anti-*H. pylori* effects. Glycyrrhiza glabra showed anti-*H. pylori* activity in vitro and its possible mechanism of acts against *H. pylori* include inhibiting protein synthesis, DNA gyrase and dihydrofolate reductase. Another study showed that an aqueous extract of glycyrrhiza glabra significantly inhibited *H. pylori* adhesion to human stomach tissue.

**Figure 5** Subgroup analysis for *H. pylori* eradication rate in different species of polyphenol compounds.
in vivo approach to evaluating the efficacy of fresh broccoli sprouts demonstrated that oral treatment of C57BL mice with broccoli sprouts resulted in a reduction in *H. pylori* colonisation. A study reported that broccoli sprout extract containing sulforaphane prevented lipid peroxidation in the gastric mucosa and may play a cytoprotective role in *H. pylori*-induced gastritis. The appropriate doses of these polyphenol compounds for eradicating *H. pylori*

Two articles about curcumin were included in this meta-analysis. After carefully reading these two articles, we discovered that curcumin (700mg, three times a day, 4 weeks) could be a useful supplement of triple therapy to eradicate *H. pylori*. The meta-analysis included four articles about cranberries. These findings suggest that cranberries can be used as a daily diet supplement (240mL, two times per day, 8 weeks) to help suppress *H. pylori* infection. Furthermore, adding cranberry (500mg, two times per day, 2 weeks) to lansoprazole, clarithromycin and amoxicillin triple therapy for *H. pylori* has a higher eradication rate than the standard regimen alone. This meta-analysis included four studies about liquorice. One showed that GutGard (150mg, one time per day,60 days) is more effective than the placebo in treating *H. pylori*. Furthermore, liquorice (380mg, two times per day, 2 weeks) is commonly added to triple or quadruple schemes. This meta-analysis included one study on garlic, which did not support a role for garlic in the treatment of *H. pylori* infection. More relevant research articles must be included in the future to determine the effective dose of garlic to eradicate *H. pylori*. Furthermore, broccoli sprout powder (6g, one time per day, 4 weeks) plus standard triple therapy affect *H. pylori* eradication.

CONCLUSION

In conclusion, current evidence suggests that polyphenol compounds (curcumin, cranberry, garlic, liquorice and broccoli) can improve eradication rates. Furthermore, polyphenol compounds combined with standard triple therapy for *H. pylori* infection can significantly improve eradication. However, no evidence for an increased rate of side effects could be found. Due to the low quality of the included studies, these results should be interpreted with caution. More large-scale, high-quality clinical trials should be conducted to provide a stronger, evidence-based foundation for guiding clinical medication.

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