An Appraisal of Drug-Drug Interactions with Green Tea (Camellia sinensis)

ABSTRACT
This review summarizes published in vitro, animal, and clinical studies investigating the effects of green tea (Camellia sinensis) extract and associated catechins on drug-metabolizing enzymes and drug transporters. In vitro studies suggest that green tea extract and its main catechin, (-)-epigallocatechin-3-gallate, to varying degrees, inhibit the activity of CYP1A1, CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2D6, and CYP3A4. UGT1A1 and UGT1A4 isoforms were also inhibited by (-)-epigallocatechin-3-gallate. Animal studies suggest green tea extract and/or (-)-epigallocatechin-3-gallate significantly increase the bioavailability of diltiazem, verapamil, tamoxifen, simvastatin, 5-fluorouracil, and nicardipine. Conversely, green tea extract and/or (-)-epigallocatechin-3-gallate reduce the bioavailability of quetiapine, sunitinib, clozapine, and nadolol. Of the few clinical studies available for review, it appears neither green tea extract nor (-)-epigallocatechin-3-gallate inhibit any major cytochrome P450 enzyme. Regarding drug transporters, in vitro studies indicate P-glycoprotein, organic anion transporting polypeptide 1A1, organic anion transporting polypeptide 1B1, organic anion transporting polypeptide 1B3, organic anion transporting polypeptide 2B1, organic cation transporter 1, organic cation transporter 2, multidrug and toxin extrusion 1, and multidrug and toxin extrusion 2-K are potentially inhibited by green tea extract. A clinical study indicates the organic anion transporting polypeptide 1A1 transporter is inhibited by (-)-epigallocatechin-3-gallate while P-glycoprotein is unaffected. In conclusion, the ingestion of green tea extract or its associated catechins is not expected to result in clinically significant influences on major cytochrome P450 or uridine 5'-diphospho-glucuronosyltransferase enzyme substrates or drugs serving as substrates of P-glycoprotein. However, some caution is advised in the consumption of significant amounts of green tea beverages or green tea extract in patients prescribed known substrates of organic anion transporting polypeptide, particularly those with a narrow therapeutic index.

Introduction
Tea is one of the most popular and widely consumed beverages in the world. Tea is prepared from the leaves of the plant Camellia sinensis L., which belong to the family Theaceae [1]. White tea, oolong tea, black tea, and green tea are all harvested from this plant, but are processed differently and attain different levels of oxidation [2]. Green tea is a non-fermented (non-oxidized) tea and as such contains a greater catechin content than either black tea or oolong tea. To produce green tea, freshly harvested leaves are stabilized by dry heating or steaming to inactivate polyphenol oxidase enzymes and then are dried rapidly, thereby preserving much of the tea’s polyphenol content [1]. Green tea originated in China and subsequently spread to the surrounding Asian countries, both as a beverage and in use for its medicinal properties.
The majority of purported therapeutic benefits of green tea are attributed to catechins, a class of flavonoids that exert potent antioxidant activity (Fig. 1). The major catechin present in green tea is EGCG, which accounts for up to 50% of total polyphenol content and possesses the highest antioxidant potential of any tea catechin assessed [2, 3]. Other catechins found in green tea in lesser abundance include ECG, EGC, and EC [4]. The high catechin content is suggested to underpin the significant antioxidant properties of green tea and its proposed protective roles in a host of pathological conditions caused by reactive oxygen species [5]. Green tea/EGCG has been reported to produce a number of positive health benefits, including cancer chemoprevention, improved cardiovascular health, enhanced weight loss, improved glycemic control, and other favorable effects [5–10].

Because of the widespread and regular use of green tea as a beverage and/or dietary supplement, the concurrent use of the plant extract with one or more conventional medications is essentially unavoidable. Importantly, a number of botanical extracts are recognized as posing a drug interaction liability when combined with conventional therapeutics [11]. Pharmacokinetic drug interactions in particular remain a significant clinical concern. The majority of botanical-drug interactions involve the drug metabolizing enzymes (DMEs) CYP and UGT, as well as selected drug transporters. The pharmacokinetic-based dietary supplement-drug interactions may occur through the alteration of drug absorption, distribution, metabolism, and/or excretion. The modulation of intestinal enzymes as well as the uptake and efflux transporters by herbal or phytochemical supplements may affect the rate and extent of drug absorption. However, the modulation of hepatic/renal uptake and efflux transporters and/or the inhibition/induction of DMEs can affect the drug’s metabolism and excretion significantly in some instances. Most of the reported supplement-drug interactions are caused by the modulation of DMEs and/or transporters in the intestine and liver, which could lead to therapeutic failure or toxicity.

A number of in vitro, animal, and clinical studies have been conducted to evaluate the potential of green tea or one or more of its constituents to modulate the activity of DMEs and/or drug transporters. Accordingly, the primary aim of the present paper is to review and summarize studies with regard to the potential of green tea or its constituents to interact with DMEs and/or drug transporters.

Methods

Computerized systematic literature searches were conducted in MEDLINE (PubMed) and Google Scholar databases through September 2016 to retrieve all pertinent studies, reviews, and case reports. Cross-referencing of published bibliographies yielded some additional reports. Drug interaction assessments were divided into three main categories: i) in vitro studies, ii) animal studies, and iii) clinical studies, which included case reports. The search terms that were utilized were green tea or *Camellia sinensis* or epigallocatechin gallate (EGCG) in combination with the terms cytochrome P450, CYP, or uridine 5′-diphospho-glucuronosyltransferase, UGT, and transporter as well as the terms inhibition and induction. Only papers published in the English language were evaluated. No other limitations were applied.

Results

An array of in vitro, animal, and clinical drug interaction studies involving green tea or one or more of its components employing various study paradigms, drug substrates, and assessment tools...
Table 1: In vitro studies evaluating the effect of GTEs on enzyme activity.

<table>
<thead>
<tr>
<th>Green tea preparation and exposure</th>
<th>Enzyme substrate</th>
<th>System</th>
<th>Result</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGCG and ECG</td>
<td>CYP1A1 (Ethoxycoumarin) CYP1A2 (Ethoxyresorufin) CYP2A6 (Coumarin) CYP2C9 (Diclofenac) CYP2E1 (Nitrophenol) CYP3A4 (Midazolam)</td>
<td>cDNA-expressed isoenzyme (S. typhimurium TA 1538 cells)</td>
<td>Catechins ↓ CYP1A1 ↓ CYP1A2 ↓ CYP3A4 ↔ CYP2C9 ↔ CYP2E1 ↔ CYP2A6 EGCG ↓ CYP1A1 (Ki 17 µM) ↓ CYP1A2 (Ki 10 µM) ↓ CYP3A4 (Ki 41 µM) ↓ CYP2C9 (Ki 18 µM) ↓ CYP2E1 (Ki 58 µM) ↓ CYP2A6 (Ki 13 µM)</td>
<td>[12]</td>
</tr>
<tr>
<td>GTE</td>
<td>CYP2C9 (Tolbutamide) CYP2D6 (Bufuralol) CYP3A4 (Testosterone)</td>
<td>HLM</td>
<td>↓ CYP2C9 (IC50 57 µg/mg protein) ↓ CYP2D6 (IC50 50 µg/mg protein) ↓ CYP3A4 (IC50 63 µg/mg protein)</td>
<td>[13]</td>
</tr>
<tr>
<td>GTC (EGCG, ECG, EGC, and EC)</td>
<td>CYP3A4 (Irinotecan)</td>
<td>HLM</td>
<td>EGC 10 µM ↓ CYP3A4 35 % EGCG, ECG, EC 100 µM ↓ CYP3A4 47 %</td>
<td>[14]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hepatocytes</td>
<td>GTC ↔ CYP3A4</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Hepatocytes</td>
<td>EGC 2 µM ↑ UGT1A1 60–160 % ECG 2 µM ↑ UGT1A1 40–130 %</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Hepatocytes</td>
<td>EGCG 2 µM ↑ UGT1A1 50–80 %</td>
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<tr>
<td></td>
<td></td>
<td>Hepatocytes</td>
<td>UGT1A1 mRNA expressed in hepatocytes</td>
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<tr>
<td></td>
<td></td>
<td>UGT1A1 (Irinotecan)</td>
<td>GTC 2 µM ↑ UGT1A1</td>
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<tr>
<td></td>
<td></td>
<td>UGT1A1 (Irinotecan)</td>
<td>GTC 2 µM ↑ UGT1A1</td>
<td></td>
</tr>
<tr>
<td>GTE EGC</td>
<td>CYP2B6 (Bupropion) CYP2C8 (Amodiaquine) CYP2C19 (S-mephenytoin) CYP2D6 (Dexmetromorphphan) CYP3A4 (Midazolam)</td>
<td>HLM</td>
<td>GTE ↓ CYP2B6 IC50 6 µg/mL ↓ CYP2C8 IC50 5 µg/mL ↓ CYP3A4 IC50 14 µg/mL ↔ CYP2C19 IC50 49 µg/mL ↔ CYP2D6 IC50 25 µg/mL EGCG ↓ CYP2B6 IC50 8 µM ↓ CYP2C8 IC50 11 µM ↓ CYP3A4 IC50 23 µM ↔ CYP2C19 IC50 101 µM ↔ CYP2D6 IC50 69 µM</td>
<td>[15]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HLM</td>
<td>GTE ↓ CYP3A4 IC50 18 µg/mL</td>
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<tr>
<td></td>
<td></td>
<td>HLM</td>
<td>EGCG ↓ CYP3A4 IC50 31 µM</td>
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</tbody>
</table>

continued
were retrieved and reviewed. Findings from these reports are summarized and presented in Tables 1–4 and are specifically discussed in the ensuing sections.

**In vitro interaction assessments**

There are a number of recognized limitations of in vitro screening methodologies used to assess potential botanical supplement-drug interactions. These limitations include the arbitrary assignment of drug concentration at the enzymatic and/or drug transporter site, difficulties accounting for or even estimating pre-systemic metabolism, and the contribution of both known and unknown metabolites. Additionally, single botanical constituents are often used in testing, which are not reflective of typical multi-constituent extracts that are ingested [41]. In spite of these limitations, in vitro studies remain the mainstay of the initial evaluation of promising lead compounds in conventional medicine, and the assessment of botanical compounds in the pre- and post-marketing periods. The widespread use of in vitro methods is largely due to the high throughput nature of these investigations and the substantially reduced costs relative to in vivo studies. Furthermore, “positive” results, particularly if replicated and at physiologically relevant concentrations, can serve as the basis for the performance of more rigorous clinical studies. Studies of green tea employing in vitro methodologies are highlighted in Tables 1 and 2.

**Cytochrome P450 enzymes**

**Metabolic inhibition**

Screening for metabolic inhibition of one or more hepatic enzymes (e.g., CYP 450) has become one of the more routine (and in some instances required) assessments of a conventional drug or dietary supplement proposed for clinical use. The effects of green tea catechins on CYP enzymes were studied by Muto and colleagues utilizing a genetically modified cell line and they were found to inhibit several of the enzymes assessed [12]. The catechins evaluated as potential inhibitors in the study were obtained from Sigma-Aldrich with the exception of EGCG, which was obtained from Wako Pure Chemical Industries. The inhibitory effect of green tea catechins on human CYP1A1, CYP1A2, CYP2A6, CYP2C9, CYP2E1, and CYP3A4 were examined in genetically engineered *Salmonella typhimurium* TA 1538 cells. Whilst all catechins inhibited all of the tested CYP activity to some degree, EGCG was

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**Table 1 Continued**

<table>
<thead>
<tr>
<th>Green tea preparation and exposure</th>
<th>Enzyme substrate</th>
<th>System</th>
<th>Result</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>GTE EGCG</td>
<td>mRNA expression CYP1A1 CYP1A2 CYP3A4</td>
<td>LS-180 cell line</td>
<td>GTE ↑CYP1A2 7-fold ↔CYP1A1 ↔CYP3A4 [16]</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EGCG ↔CYP1A2 ↔CYP1A1 ↔CYP3A4</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Caco-2 GTE ↑CYP1A2 6-fold ↔CYP3A4</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>EGCG ↑CYP1A1 5-fold ↑CYP1A2 3-fold ↔CYP3A4</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CYP1A2 CYP3A4</td>
<td>Expessed in insect cell membranes Measuring the luminescent signal of CYP1A2 demthylation and CYP3A4 debnezylation by</td>
</tr>
<tr>
<td>GTC (C, EC, ECG, EG, GC, GCG, EGG)</td>
<td>CYP1A2 CYP2C9 CYP2D6 CYP3A4</td>
<td>HLM</td>
<td>CYP1A2 ↓IC50 8.9 µM</td>
<td>[17]</td>
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<tr>
<td></td>
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<td></td>
<td>GTC 0.1 mg/mL ↓CYP2C9 IC50 7.6 µM</td>
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<td></td>
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<td></td>
<td>GTC 1 mg/mL ↓CYP3A4 IC50 45%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>EGCG 402 µM ↓CYP2C9 IC50 7.6 µM</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EGCG 402 µM ↓CYP3A4 IC50 45%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>EGCG UGT1A4 IC50 74 µM</td>
<td>[18]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EGCG UGT1A1 IC50 17 µM</td>
<td>[19]</td>
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<table>
<thead>
<tr>
<th>Green tea preparation and exposure</th>
<th>Transporter System</th>
<th>Result</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GTE</strong></td>
<td>Estrone-3-sulfate OATP-B</td>
<td>Human embryonic kidney 293 cells (HEK293)</td>
<td>↓ OATP-B 82%</td>
</tr>
<tr>
<td><strong>EGCG</strong></td>
<td>Estrone-3-sulfate OATP1A2</td>
<td>HEK293</td>
<td>ECG</td>
</tr>
<tr>
<td><strong>EGCG</strong></td>
<td>OATP1B1, OATP1B3, OATP2B1</td>
<td>CHO cells</td>
<td></td>
</tr>
<tr>
<td><strong>EGCG</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>GTE</strong></td>
<td>Nadolol (OATP1A2)</td>
<td>HEK293</td>
<td>↓ OATP1A2</td>
</tr>
<tr>
<td><strong>GTE</strong></td>
<td>P-glycoprotein (P-gp) MRP2 (Methotrexate) (Glutathione methylfluorescein)</td>
<td>LS-180 cell line</td>
<td>GTE 0.01 mg/mL +P-gp +MRP2</td>
</tr>
<tr>
<td><strong>GTE</strong></td>
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<tr>
<td><strong>GTE</strong></td>
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<tr>
<td><strong>GTP</strong></td>
<td>P-gp</td>
<td>CHO cell line</td>
<td>GTP 10 µg/mL J P-gp 50% photolabeling (1 accumulation of R-123 by 2.2-fold with 15 µg/mL)</td>
</tr>
<tr>
<td><strong>EGCG</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>GTE</strong></td>
<td>OATP1B1, OATP1B3 [Bromosulphophthalein (BSP), atorvastatin]</td>
<td>HEK</td>
<td>GTE with BSP ↓ OATP1B1 IC50 2.6% (v/v) ↓ OATP1B3 IC50 0.39% (v/v)</td>
</tr>
<tr>
<td><strong>EGCG</strong></td>
<td>OCT1 OCT2 MATE1 MATE2-K (Metformin)</td>
<td>HEK</td>
<td>GTE with metformin ↓ OCT1 IC50 1.4% (v/v) ↓ OCT2 IC50 7% (v/v) ↓ MATE1 IC50 4.9% (v/v) +MATE2-K</td>
</tr>
<tr>
<td><strong>EGCG</strong></td>
<td>P-gp (Digoxin)</td>
<td>Caco-2</td>
<td>GTE 1% (v/v) with digoxin J P-gp 25%</td>
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</table>

*continued*
Irinotecan is a topoisomerase inhibitor used in the treatment of a number of cancers. Irinotecan is also a prodrug that is activated to its active metabolite SN-38. There are two primary detoxification pathways for irinotecan, the one for SN-38 is governed by specific UDP-glucuronosyltransferases (UGTs) to form the inactive SN-38 glucuronide, while irinotecan itself is subject to oxidative metabolism via CYP3A4 and 3A5 into the inactive metabolites APC (7-ethyl-10-[4-N-(5-aminoxytanoic acid)-1-piperidino] carbonyxamptothecin) and NPC (7-ethyl-10-[4-(1-piperidino)-1-amino] carbonyxamptothecin). The effect of GTCs (Sigma-Aldrich) on irinotecan metabolism by CYP3A4 into its inactive ox-

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**Table 2 Continued**

<table>
<thead>
<tr>
<th>Green tea preparation and exposure</th>
<th>Transporter</th>
<th>System</th>
<th>Result</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>GTE</td>
<td>OCT2</td>
<td>Rat renal cortical slices</td>
<td>GTE ↓ OCT1 IC50 2.7 mg/mL</td>
<td></td>
</tr>
<tr>
<td>GTC</td>
<td>1-methylphenylpyridinium (MMP+)</td>
<td></td>
<td>ECG ↓ OCT1 IC50 0.87 mM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>S2 stably expressing rat OCT2</td>
<td></td>
<td>ECG ↓ OCT1 IC50 1.67 mM</td>
<td></td>
</tr>
</tbody>
</table>

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reported a far more potent inhibitor than the other catechins assessed. The inhibitory constant (Ki) values in the inhibition of CYP1A1, CYP1A2, CYP2A6, CYP2C9, CYP2E1, and CYP3A4 were 17 µM, 10 µM, 41 µM, 18 µM, 58 µM, and 13 µM, respectively [12]. Nishikawa and associates (2004) investigated the effect of GTE, which was prepared by extraction of Chinese tea leaves with aqueous ethanol, in CYP enzyme activities using HLMs. Effects were tested on CYP2C9, CYP2D6, and CYP3A4 and it was found that all isoforms were inhibited modestly. The one-half maximal inhibitory concentration (IC50) for inhibiting CYP2C9, CYP2D6, and CYP3A4 were reported as 57 µg/mg protein, 50 µg/mg, and 63 µg/mg, respectively [13]. Another study examined the effect of GTE (EFLAr942) that was obtained from Frutarom Switzerland Ltd. and EGCG that was provided from CHEMOS GmbH on the activity of CYP1A2 and CYP3A4 that was expressed in insect cell membranes. The study found that both GTE and EGCG inhibit the activity of CYP1A2 and CYP3A4 in a concentration-dependent manner. The 0.1 mg/mL of GTE and 402 µg/mL of EGCG reduced the activity of CYP1A2 by approximately 45% compared to the control (in the absence of GTE or EGCG). Moreover, 1 mg/mL GTE and 402 µg/mL of EGCG decreased the activity of CYP3A4 approximately 45 and 25%, respectively [16]. The concentrations used in this study were relatively high compared to the reported concentrations of green tea catechins in humans (EGCG around 300-600 ng/mL and EGC around 550-1500 ng/mL) [42,43].

Irinotecan is a topoisomerase inhibitor used in the treatment of a number of cancers. Irinotecan is also a prodrug that is activated to its active metabolite SN-38. There are two primary detoxification pathways for irinotecan, the one for SN-38 is governed by specific UDP-glucuronosyltransferases (UGTs) to form the inactive SN-38 glucuronide, while irinotecan itself is subject to oxidative metabolism via CYP3A4 and 3A5 into the inactive metabolites APC (7-ethyl-10-[4-N-(5-aminoxytanoic acid)-1-piperidino] carbonyxamptothecin) and NPC (7-ethyl-10-[4-(1-piperidino)-1-amino] carbonyxamptothecin). The effect of GTCs (Sigma-Aldrich) on irinotecan metabolism by CYP3A4 into its inactive ox-

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Metabolic induction

There are limited in vitro data assessing potential metabolic induction by GTE or its constituents. In one study, GTE (EFLAr942; Frutarom Switzerland Ltd.) but not EGCG (CHEMOS GmbH) was shown to increase CYP1A2 mRNA expression in an LS-180 up to 7-fold. However, neither CYP1A1 nor CYP3A4 were induced by GTE or EGCG [16]. In Caco-2, GTE and EGCG both induced CYP1A1 and CYP1A2 mRNA expression in a dose-dependent approach. GTE significantly increased mRNA expression of CYP1A1 and CYP1A2 by 25- and 6-fold, respectively, and EGCG increased mRNA expression of CYP1A1 and CYP1A2 by 5- and 3-fold, re-
spectively [16]. In contrast to the aforementioned study, Mirkov
and colleagues (2006) investigated the influence of green tea cate-
chins (Sigma-Aldrich) on CYP3A4 activity using human hepato-
cytes and reported that neither EGCG, ECG nor EGC induced
CYP3A4 activity [14].

Uridine 5′-diphospho-glucuronosyltransferase
enzyme

Uridine 5′-diphospho-glucuronosyltransferase
enzyme inhibition

Drug metabolism by phase II enzymes mainly occurs via conjuga-
tion with glucuronic acid (glucuronidation) and to a lesser degree
through sulphation, methylation, and glutathione conjugation
[44]. The UGTs are a superfamily of 18 different enzymes involved
in the metabolism of almost 10% of the top 200 prescribed drugs
[45]. The glucuronidation of EGCG and EGC were investigated us-
ing HLM and UTG expressed isozymes. EGCG was determined to
be glucuronidated predominantly by UGT1A1, 1A8, and 1A9
[46]. Irinotecan is largely metabolized by UGT1A1 to 7-ethyl-10-
hydroxycamptothecin glucuronide (SN-38G) [47]. Green tea cate-
chins (Sigma-Aldrich) were found to decrease the formation of
SN-38G in HLMs due to the inhibition of UGT1A1 activity. Among
the green tea catechins, ECG and EGCG have produced the high-
est degree of inhibition of SN-38G formation. A concentration of
100 µM of both ECG and EGCG produced more than 80% in-
hibition of SN-38G formation compared to the control [14].

Mohamed and coworkers [19] also reported that EGCG (Sigma-
Aldrich) inhibited the activity of UGT1A1 in HLMs with a reported
IC50 of 17 µM. Mohamed and Frye [18] assessed the effect of
EGCG (Sigma-Aldrich) on UGT1A4, 1A6, and 1A9 using HLMs.
EGCG was found to inhibit UGT1A4 with an IC50 value of 74 µM.

Uridine 5′-diphospho-glucuronosyltransferase
enzyme induction

Few studies have evaluated the potential induction of UGT en-
zymes by green tea or its constituents. However, at least one
study has assessed the effect of the green tea catechins EGCG, EGC,
and EGC (Sigma-Aldrich) on irinotecan glucuronidation via
UGT1A1 in human hepatocytes. Mirkov and coworkers reported
that EGCG, EGC, and EGC at 2 µM slightly increased the pro-

<table>
<thead>
<tr>
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<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGCG (100 mg/kg)</td>
<td>Sunitinib</td>
<td>48% reduction in C&lt;sub&gt;max&lt;/sub&gt;</td>
<td>[27]</td>
</tr>
<tr>
<td>EGCG (1,4,12 mg/kg)</td>
<td>Diltiazem</td>
<td>19–44% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
<td>[28]</td>
</tr>
<tr>
<td>EGCG</td>
<td>Verapamil</td>
<td>43% decrease in CL/F</td>
<td>[29]</td>
</tr>
<tr>
<td>2 mg/kg</td>
<td>Nicardipine</td>
<td>52% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>10 mg/kg</td>
<td></td>
<td>87% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
<td></td>
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<tr>
<td>0.5 mg/kg</td>
<td></td>
<td>19% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
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<td>3 mg/kg</td>
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<td>56% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
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<tr>
<td>10 mg/kg</td>
<td></td>
<td>88% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>Green tea (50 mg/kg)</td>
<td>5-Fluorouracil</td>
<td>151% increase in C&lt;sub&gt;max&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>Green tea (175 mg/kg)</td>
<td>Clozapine</td>
<td>43% increase in C&lt;sub&gt;max&lt;/sub&gt;</td>
<td></td>
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<tr>
<td>EGCG</td>
<td>Tamoxifen</td>
<td>15% increase in AUC&lt;sub&gt;0–∞&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>10 mg/kg</td>
<td>Nadolol</td>
<td>85% decrease in C&lt;sub&gt;max&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>Green tea (100 mg/kg)</td>
<td>Simvastatin</td>
<td>230% increase in C&lt;sub&gt;max&lt;/sub&gt;</td>
<td></td>
</tr>
<tr>
<td>GTE (400 mg/kg)</td>
<td>Quetiapine</td>
<td>34% decrease in C&lt;sub&gt;max&lt;/sub&gt;</td>
<td></td>
</tr>
</tbody>
</table>
tion of SN-38G by 60–160, 40–130, and 50–80%, respectively, relative to the study control. However, in a Hep G2 cell culture, the selected catechins were found to have no influence on the formation of the irinotecan metabolite SN-38G. Moreover, the level of UGT1A1 mRNA that was expressed in human hepatocytes was not significantly increased [14].

**Drug transporters**

Although the majority of the published drug-botanical interaction studies focus on the inhibition of DMEs, the role of drug transporters in these interactions is of increasing interest to the field. A study involving HEK 293 cells stably expressing OATP B transporter (OATP-B) tested the effect of groups of botanical extracts and phytochemicals on the function of this transporter, which is expressed on intestinal epithelial cells and plays a role in the absorption of many drugs [20]. The study indicated that GTE (Tokiwa Phytochemical Co.) and EGCG (Extrasynthese S. A.) potently inhibited the uptake of the prototypical substrate estrone-3-sulfate by 82 and 75%, respectively, compared to a control [20]. Another *in vitro* study examined the effect of the green tea catechins, ECG, and EGCG on the mRNA expression level of P-gp and multidrug resistance associate protein 2 (MRP2) in human gastrointestinal epithelial LS-180 cells. The mRNA expression of P-gp and MRP2 were not changed by GTE at 0.01 mg/mL. However, it was noted that GTE at 1 mg/mL, but not EGCG, inhibited MRP2 activity and therefore increased the methotrexate permeability by almost 2-fold [23]. The effect of GTPs and EGCG on P-gp was also studied in a CHO cell line (CHRC5). GTPs were from LKT Laboratories and EGCG was from Sigma-Aldrich. GTPs at a concentration of 10 g/mL reduced P-gp photolabeling by 50%. The accumulation of R-123 was increased by 2.2- and 8.3-fold at concentrations of 15 g/mL and 300 g/mL, respectively. In addition, EGCG was found to inhibit P-gp and increased the accumulation of R-123 by almost 4-fold at a concentration of 100 µM [24]. The concentrations of GTPs and EGCG that resulted in the inhibition on P-gp in this study were quite high and likely beyond those that would be achieved in humans receiving even high doses of GTPs or GTE.

In addition, a recent *in vitro* study found that GTE (Healthya green tea) and EGCG (University of Shizuoka, Japan) inhibited the uptake efficiency of OATP1B1, OATP1B3, organic cation transporter (OCT1), and OCT2 as well as the multidrug and toxin extrusion (MATE)1 and MATE2-K transporters, and the P-gp efflux transporter. Uptake of the substrate bromosulphophthalein (BSP) by OATP1B1 and OATP1B3 in a human embryonic kidney (HEK) cell line was inhibited by GTE with IC50 of 2.6% (v/v) and 0.39% (v/v), respectively. Moreover, the uptake of BSP by OATP1B1 and OATP1B3 was reduced by EGCG to 64 and 12%, respectively, of

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**Table 4** Clinical studies evaluating the effect of green tea on drug-metabolizing enzyme and transporter activity.

<table>
<thead>
<tr>
<th>Green tea preparation and exposure</th>
<th>Drug</th>
<th>Result</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGCG (800 mg/day)</td>
<td>Caffeine (CYP1A2)</td>
<td>No significant effect on CYP1A2 or CYP2D6</td>
<td>[37]</td>
</tr>
<tr>
<td></td>
<td>Dextromethorphan (CYP2D6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decaffeinated GTE (211 mg of catechins)</td>
<td>Dextromethorphan (CYP2D6)</td>
<td>No significant effect on CYP2D6 or CYP3A4</td>
<td>[38]</td>
</tr>
<tr>
<td>EGCG</td>
<td>Iron isotopes (57Fe)</td>
<td>Minor reduction on Iron absorption</td>
<td>[39]</td>
</tr>
<tr>
<td>(150 mg/day)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(300 mg/day)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GTE (0.3 g/250 mL)</td>
<td>Folic acid (0.4 mg)</td>
<td>39% decrease Cmax</td>
<td>[40]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27% decrease AUC</td>
<td></td>
</tr>
<tr>
<td>Folic acid (5 mg)</td>
<td></td>
<td>27% decrease Cmax</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% decrease AUC</td>
<td></td>
</tr>
<tr>
<td>Green tea (700 mL/day)</td>
<td>Nadolol (OATP1A2)</td>
<td>Inhibition of OATP1A2 uptake</td>
<td>[22]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>85% decrease Cmax</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>85% decrease AUC</td>
<td></td>
</tr>
</tbody>
</table>

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For the full citation, please refer to the original article.
stromal tumor patients, and EGCG (Sigma-Aldrich) were directly
metastatic renal cell carcinoma and advanced gastrointestinal
nib, an orally administered tyrosine kinase inhibitor used to treat
formin in HEK transfected cells by OCT1, OTC2, and MATE1 was
in the absence of EGCG. The uptake of the known substrate met-
reduced by EGCG to 64 and 43%, respectively, of the net uptake
respectively. The uptake of atorvastatin by OATP1B1 and OATP1B3
was inhibited only by GTE and EGCG with IC50s of 1.9% (v/v) and 1% (v/v), respec-
tively. The Cmax and the area under the plasma concentration-time curve
(AUC) extrapolated to infinity (AUC∞) of sunitinib plasma, after
ingesting EGCG, were reduced by 48 and 52%, respectively [27].

Another investigation assessed the influence of different EGCG
(Sigma-Aldrich) doses (1, 4, 12 mg/kg) administrated orally on the
pharmacokinetics of orally (12 mg/kg) and intravenous (5 mg/kg) diltiazem, a calcium channel blocker (CCB), and its pri-
ary active metabolite, desacetyldiltiazem, whose formation is
mediated through CYP3A4 in humans. Further, both compounds
are substrates of P-gp. The study was conducted in male Sprague-
Dawley rats and the oral doses of EGCG and diltiazem (both were
dissolved in water) were given by gavage, while the intravenous
dose of diltiazem (was dissolved in 0.9% NaCl) was given through
the femoral vein. The peak concentration (Cmax) and the AUC of
diltiazem increased significantly when administered concurrently
with EGCG. In addition, the increase of Cmax and AUC of diltiazem
was associated with the increase of the EGCG dose. The AUC
of oral diltiazem increased from 19 to 44% depending on the doses
of EGCG administered, and increased 80% after intravenous dos-
ing. The total clearance (CL/F) decreased by 43% when EGCG was
coadministered with diltiazem. The desacetyldiltiazem-diltiazem
AUC ratio decreased to a non-significant degree; therefore, it was
suggested the EGCG may increase the Cmax and AUC of diltiazem
via inhibition of CYP3A4-mediated metabolism and P-gp-mediat-
ed efflux in the intestine [28].

Verapamil, also a CCB, is an antihypertensive and antiarrhyth-
ic agent extensively metabolized in the liver by CYP3A4 to nor-
verapamil. In addition, verapamil is known to be a P-gp substrate.
A study was conducted in Sprague-Dawley rats to evaluate the ef-
effect of EGCG (Sigma-Aldrich) on 9 mg/kg verapamil pharmaco-
kinetics (both were dissolved in water). The 2-mg/kg dose of
EGCG increased the AUC by 52% and the 10-mg/kg dose in-
creased the AUC by 87% compared with the controls. Since the
AUC of verapamil and norverapamil both increased in the pres-
ence of EGCG, the inhibition seemed to be on P-gp [29]. In addi-
tion to verapamil, nicardipine, another CCB, was coadministered
with EGCG (Sigma-Aldrich) in male Sprague-Dawley rats (both
were dissolved in water) to assess the effect of EGCG on CYP3A4
and intestinal P-gp. The coadministration of 0.5, 3, and 10 mg/kg
EGCG increased the AUC of orally administered nicardipine (12 kg/
ml) by 19, 56, and 88%, respectively. Nevertheless, EGCG did not
significantly increase the AUC of intravenously administered nicar-
dipine (4 mg/kg). These results, according to the investigators,
suggest that EGCG inhibited both hepatic CYP3A and intestinal P-gp [30].

Green tea is frequently consumed by patients undergoing che-
motherapeutic regimens for cancer [48]. However, there are only
a limited number of studies on the effect of the coadministration
of green tea with anticancer drugs. To investigate the potential ef-
effects of consuming GTE (Lipton green tea) on the pharmaco-
kinetics of 5-fluouracil (5-FU), Qiao et al. studied the effect of
orally administered green tea dissolved in water (50 mg/kg) on the
pharmacokinetics of a single intraperitoneal injection of 5-FU
(48 mg/kg) in male Sprague-Dawley rats. The study found the

Interaction assessments using animal models

The use of animal models in research on drug interactions is not
uncommon, but of limited utility due to a variety of factors, not
the least of which are interspecies differences in metabolism, dos-
ing, and response that can severely limit the predictive value of
the results obtained [41]. Nevertheless, a number of studies using
rodents have investigated the impact of administering GTE or spe-
cific green tea constituents on the pharmacokinetics of clinically
prescribed medications and are highlighted in Table 3. Suniti-
nib, an orally administered tyrosine kinase inhibitor used to treat
metastatic renal cell carcinoma and advanced gastrointestinal
stromal tumor patients, and EGCG (Sigma-Aldrich) were directly
administered into the stomach (by gastric gavage) of male
Sprague-Dawley rats. The doses of sunitinib and EGCG (both were
dissolved in water) were 30 mg/kg and 100 mg/kg, respectively.
The Cmax and the area under the plasma concentration-time curve
(AUC) extrapolated to infinity (AUC∞) of sunitinib plasma, after
ingesting EGCG, were reduced by 48 and 52%, respectively [27].

In summary, a substantial number of in vitro studies have been
carried out that have utilized a variety of assay methods and eval-
uated a number of differently sourced green tea extracts. The ma-
majority of which suggest that GTE or its components may signifi-
cantly inhibit one or more CYP enzymes (Table 1). Among the
CYP enzymes assessed, CYP1A2 and CYP3A4 were reportedly in-
hibited by GTE, EGC, and EGCG. The CYP2B6, CYP2C8, and
CYP2C9 enzymes were inhibited by both GTE and EGCG. The
CYP2D6 enzyme was inhibited only by GTE, and CYP2E1 was in-
hibited only by EGCG. Few studies evaluated the induction of
CYP enzymes by GTE and EGCG. CYP1A1 and CYP1A2 were both
inhibited only by GTE, EGC, and EGCG. With regard to UGT enzymes, EGCG
was found to inhibit UGT1A1 and UGT1A4 and at low concen-
trations, EGC, EGC, and EGC were found to induce UGT1A1 (Table 1).
Regarding drug transporters, GTE and EGCG were reported to
inhibit the efflux transporters P-gp, MRP, and MATE (Table 2).
Furthermore, transporters OATP-A, OATP-B, OCT1, and OCT2 up-
take efficiencies were inhibited by GTE and EGCG in in vitro stu-
dies. Additionally, the influx transporter OATP1B3 was induced by
EGCG [12–26].
AUC of 5-FU increased by 524% and the $C_{\text{max}}$ increased by 151% in the green tea-treated group compared with the controls. The investigators suggested that patients habitually drinking green tea might be candidates for therapeutic drug monitoring if it were consumed concurrently with 5-FU [31].

The effect of GTE (Exolise Alkopharma) administration on the pharmacokinetics of clozapine was studied in male Sprague-Dawley rats. Clozapine, an atypical antipsychotic drug, is predominantly metabolized via CYP1A2 to its primary metabolite N-desmethylclozapine in humans. Doses of 175 mg/kg of GTE (containing 22 mg of EGCG and 9 mg of caffeine) were given through an intragastric tube with clozapine 20 mg/kg. The $C_{\text{max}}$ and $AUC_{0-\infty}$ of clozapine were reduced after coadministration with GTE by 43 and 50%, respectively. The reduction in both $C_{\text{max}}$ and $AUC_{0-\infty}$ suggested potential interactions during the absorption and metabolism phases, however, the authors indicated that they could not exclude the potential influence of GTE on drug transporters [32]. Additionally, it is noted that the GTE utilized contained modest amounts of caffeine, another recognized CYP1A2 substrate that has been shown to elevate clozapine concentrations in humans, which may further cloud the interpretation of these results [49].

The influence of EGCG on the pharmacokinetics and bioavailability of tamoxifen was also examined in male Sprague-Dawley rats. Tamoxifen is an estrogen modulator metabolized to active metabolites, 4-hydroxytamoxifen and N-desmethyltamoxifen, catalyzed by CYP2D6 and CYP3A4. In addition, tamoxifen is a recognized substrate of P-gp. A 10-mg/kg dose of tamoxifen with and without 0.5, 3, and 10 mg/kg of EGCG (Sigma-Aldrich) were administered intragastrically through a feeding tube and both were dissolved in water. The mean plasma concentration time profiles of tamoxifen significantly increased after exposure to the 3 and 10 mg/kg doses of EGCG. Indeed, in the presence of EGCG (3 mg/kg), the $C_{\text{max}}$ and $AUC_{0-\infty}$ of tamoxifen increased by 36 and 32%, respectively. Furthermore, a higher dose of EGCG (10 mg/kg) resulted in a larger magnitude of increase in $C_{\text{max}}$ and $AUC_{0-\infty}$ of tamoxifen (i.e., 47 and 43%, respectively). Therefore, elevated tamoxifen plasma concentrations following EGCG coadministration could be due to the enhancement of intestinal absorption and reduction of first-pass metabolism [33]. Misaka and colleagues investigated the effect of GTE (SunphenonBG3; Taiyu Kagaku Co., Ltd.) on the pharmacokinetics of simvastatin in female Sprague-Dawley rats. Simvastatin, a lipid-lowering prodrug, is metabolized by CYP3A to its active metabolite, simvastatin acid. In this investigation, rodents were administered a single dose of GTE (400 mg/kg) that was dissolved in water and simvastatin (20 mg/kg) that was dissolved in 0.5% carboxymethylcellulose via oral gavage. The $AUC_{0-6}$ and $C_{\text{max}}$ were increased 3.4-fold and 3.3-fold, respectively, compared to the control condition. It was speculated by the investigators that the change in the simvastatin pharmacokinetics may have been the result of GTE inhibition of intestinal CYP3A activity [35]. In addition, Misaka et al. (2013) investigated the effect of GTE (SunphenonBG3) and EGCG (University of Shizuoka, Japan) on the pharmacokinetics of nadolol in male Sprague-Dawley rats. Nadolol, a non-selective beta-blocker, is not a substrate of CYP enzymes, but is a substrate for efflux and uptake transporters, primarily P-gp and OATP1A2. The animals received a single dose of GTE (400 mg/kg, dissolved in saline) or EGCG (150 mg/kg, dissolved in saline) via oral gavage, followed by a single intragastric dose of nadolol (10 mg/kg, dissolved in water). The nadolol $C_{\text{max}}$ and AUC were reduced by 85 and 74%, respectively. Moreover, the $C_{\text{max}}$ and $AUC_{0-\infty}$ of nadolol after the EGCG pretreatment were reduced by 80 and 73%, respectively. This study did not elucidate the mechanism(s) leading to the reduction of nadolol plasma concentrations, but the authors speculated that it might have been due EGCG-mediated inhibition of uptake transporter activity [34].

The effect of GTE on the pharmacokinetics of quetiapine was investigated in Wistar Albino rats. Quetiapine is an atypical antipsychotic and partial CYP3A4 substrate. The animals were administered 175 mg/kg of GTE (General Nutrition Corporation) for 7 days by oral gavage and then a single 25 mg/kg dose of quetiapine was administered intragastrically. The $C_{\text{max}}$ and $AUC_{0-\infty}$ of quetiapine were significantly reduced by more than 30%. Since the half-life and the elimination rate remained unchanged, the authors suggested a potential influence on the absorption of quetiapine [36].

Although animal studies have a number of recognized translational limitations, they are still valuable sources of data, and a number of published reports suggest that GTE or its associated catechins, particularly EGCG, inhibit the activity of few CYP enzymes (Table 3). The values of $C_{\text{max}}$ and $AUC$ of CYP3A and P-gp substrates, diltiazem, verapamil, tamoxifen, simvastatin, and nicardipine were increased after rats were exposed to EGCG, suggesting that EGCG might inhibit CYP3A and/or P-gp activities [28–30, 33, 35]. However, the $C_{\text{max}}$ and $AUC$ of other CYP3A substrates (e.g., quetiapine, sulindac) were reduced in rats administered GTE or EGCG [27, 36]. GTE decreased the $C_{\text{max}}$ and $AUC$ of clozapine in rats, ostensibly due to the metabolic induction of CYP1A2 [32]. Additionally, nadolol plasma concentrations were decreased in rats after pretreatment with GTE and EGCG, possibly through inhibition of intestinal OATP transporters [34].

Clinical studies

Formal controlled clinical studies provide the most rigorous assessment of botanical-drug interaction potential. However, these studies are infrequently performed due to their considerable expense and the resource-intensive nature of the study methodology. Standard methodologies for assessing the potential for pharmacokinetic drug-drug interactions typically involve the use of healthy non-medicated research subjects who are administered one or more “probe” drug substrate medications that are known to be predominantly metabolized or transported by a specific enzyme or drug transporter, respectively. Patients typically receive the probe medications (representing the potential “victim” drug) on two occasions, once alone, and a second time concurrently with the suspected “perpetrator” agent (e.g., GTE). On both occasions serial blood concentrations are measured to enable investigators to determine if the suspected offending agent exerted any influence on the disposition of the respective probe drug [50]. Formal clinical studies are highlighted in Table 4.

Chow and associates (2006) conducted a clinical study to assess the influence of repeated green tea catechin administration on human CYP enzyme activity. The study included 42 healthy participants who received a combination or “cocktail” of common probe substrates for the major CYP enzymes of interest at base-
In a randomized, double-blind, placebo-controlled, crossover study, the effect of EGCG on iron absorption was assessed in 30 otherwise healthy women with low iron stores. The study consisted of 3 treatment phases including placebo, 150 mg, or 300 mg EGCG (Teavigo Taiyo Kagaku Co., Ltd.) for 8 days with a washout period of 14 days. Iron isotopes were administered orally (57Fe) and intravenously (58Fe) during the last 5 days of the active treatment phase. The study results indicated a reduction in iron absorption after exposure to EGCG 150 mg and 300 mg by 14 and 27%, respectively, compared to placebo. The investigators concluded that the degree of reduced iron absorption associated with EGCG supplementation was not clinically significant [39].

In an open-labeled, randomized, crossover study, the potential interaction between green tea and black tea with folic acid supplementation was investigated. In this somewhat complicated design, seven healthy participants received five different exposures (i.e., A, B, C, D, E) separated by a one-week washout period and exposures A and B occurred twice. Exposure A consisted of 0.4 mg folic acid taken with green tea; Exposure B consisted of 0.4 mg folic acid taken with black tea; Exposure C consisted of 0.4 mg folic acid taken with water; Exposure D: consisted of 5 mg of folic acid taken with water; and Exposure E which consisted of 5 mg of folic acid taken with green tea).

Spray-dried green tea powdered extracts of green or black tea (Plantextrak) were used to prepare the study tea beverages, which were administered at a concentration of 0.3 g/250 mL. The EGCG content was reported as 207 μmol/g in the green tea and 4.4 μmol/g in the black tea. Blood samples were collected over a period of 8 h.

The study results indicated that at the 0.4-mg folic acid dose, green and black tea exposures reduced the mean Cmax of serum folate by 39.2 and 38.6%, respectively. Additionally, both green and black tea exposures reduced the mean AUC0–∞ by 26.6 and 17.9%, respectively. At the 5-mg folic acid dose, the mean Cmax of serum folate was reduced by 27.4% and the mean AUC0–∞ was decreased by 39.9% during the concurrent exposure to green tea. In summary, it appears that modest consumption of green or black tea may significantly decrease the bioavailability of folic acid supplements if administered concomitantly. The authors speculate on several mechanisms that might explain the influence of tea including inhibition of carrier-mediated absorption of folates in the small intestine or involvement of efflux transporters. In any case, these findings may be of clinical significance in certain patients being treated for a folate deficiency who are regular consumers of high amounts of tea or tea catechins on a daily basis [40].

To date, only a few clinical pharmacokinetic studies have been conducted in human subjects. Of two available studies utilizing a probe drug approach, it appears that the activities of CYP1A2, CYP2D6, CYP2C9, and CYP3A4 enzymes are unlikely to be significantly influenced by modest GTE exposure [37, 50]. This finding is generally at odds with in vitro reports, which suggested metabolic inhibition, but the disparate findings of in vitro vs. in vivo studies is not an uncommon finding in the field of botanical-drug interaction assessment [41]. An additional study assessed the influence of a green tea beverage on the pharmacokinetics of a single 30-mg dose of nadolol and reported very significant reductions in
the $C_{\text{max}}$ and $AUC_{0-48}$. The authors speculated that the likely mechanism for the interaction was the inhibition of OATP1A2-mediated nadolol uptake [22]. In two other clinical studies not assessing specific metabolic routes or transporters, a proprietary EGCG formulation was found to have no effect on iron absorption, while a GTE formulation resulted in reduced bioavailability of co-administered folic acid [39, 40].

It should be emphasized that the results of the clinical studies assessing GTE or specific catechins cannot be generalized to all botanical supplements or extracts, which can differ considerably in phytochemical content. Also, note that each of the studies discussed above utilized a different green tea/catechin formulation in their interaction assessment.

**Conclusions**

GTE and one or more of its associated catechins have been evaluated in a number of in vitro animal and clinical studies for their potential to modulate selected DMEs and drug transporters. These studies were generally conducted by independent laboratories or research programs, employed a variety of different study paradigms, assay conditions, and substrates, and assessed an array of concentrations of whole extracts and singular green tea components (e.g., EGCG). Furthermore, reviewed studies utilized GTEs and catechins sourced from an array of manufacturers. As a result, only limited conclusions may be drawn, which cannot be generalized to all green tea products.

In almost every instance in which an interaction or potential interaction was suggested by an in vitro animal or study, the results were not observed in clinical studies that have been conducted, which should have revealed them. Such discrepancies between in vitro studies of drug interactions with botanical extracts/constituents and results from clinical studies are not uncommon. These differences likely occur for a multitude of reasons, including the use of higher concentrations used to inhibit the P450 enzymes in vitro than physiologically attainable concentrations in man. There are inherent difficulties accounting for bioavailability, distribution, first-pass metabolism, and active metabolites of botanical constituents in man [41]. The in vivo concentration of a suspected inhibitor at an active or site is generally estimated and unknown in in vitro experiments and typically based upon available pharmacokinetic values when these are known, which is often not the case for botanical supplements. When these values are known, the assumption is that it is the plasma concentration presented to hepatic and CYP or other enzymes or transporters, which may also be inaccurate. Additionally, variability in the chemical composition of commercially available botanical supplements and the lack of analytical standards in some cases may contribute to the discrepancies.

In conclusion, GTE and its principal catechins, at modest consumption levels, generally appear unlikely to result in clinically significant effects on the disposition of drugs metabolized by CYP and/or UGT enzymes and do not appear to influence the fate of medications serving as substrates for the P-gp transporter. At least one small clinical study suggests that relatively modest tea consumption concurrently with folic acid may significantly reduce the bioavailability of folic acid. However, the mechanism of this effect is unclear. The disposition of drugs that are substrates of OATP transporters might be influenced by significant GTE or green tea catechin consumption. Therefore, it is recommended to avoid, or at least use caution in, consuming large amounts of green tea daily or ingesting GTE supplements in patients receiving medications known to serve as OATP substrates, particularly those which may have a narrow therapeutic index.

**Conflict of Interest**

The authors declare no conflicts of interest.

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