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## Resveratrol, human health and winemaking perspectives

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### ABSTRACT

Resveratrol, (3, 5, 4'-trihydroxystilbene) is a non-flavonoid polyphenol stilbene synthesized by plants when damaged by infectious diseases or ionizing radiation. Although present in more than seventy plant species, grapes and wine are the major dietary contributors of resveratrol, responsible for 98% of the daily intake. In 1992, Renaud and De Lorgeril first linked wine polyphenols, including resveratrol, to the potential health benefits ascribed to regular and moderate wine consumption (the so called "French Paradox"). Since then, resveratrol has received increasing scientific interest, leading to research on its biological actions, and to a large number of published papers, which have been collected and discussed in this review. The relatively low amounts of resveratrol measured in wine following moderate consumption, however, may be insufficient to mitigate biological damage, such as that due to oxidative stress. On this basis, the authors also highlight the importance of viticulture and the winemaking process to enhance resveratrol concentrations in wine in order to bolster potential health benefits.

**Abbreviations:** ALT: Alanine aminotransferase; AMPK: AMP-activated protein kinase; APC: Antigen presenting cells; ApoB100: Apolipoprotein B100; ApoB48: Apolipoprotein B48; AUC: Area Under the Curve; BMI: Body Mass Index; BNP: Brain Natriuretic Peptide; CAD: Coronary Artery Disease; CCL3: Chemokine (C-C motif) ligand 3; CCND2: G1/S specific cyclin-D2 gene; CF: Calcium Fructoborate; cps: capsules; CRP: C-Reactive Protein; CVD: Cardiovascular disease; CYPs: Cytochromes; CYP1A2: Cytochrome P450 1A2; CYP2D6: Cytochrome P450 2D6; CYP3A4: Cytochrome P450 3A4; FMD: Flow Mediated Dilatation; GE: Grape extract; GE-RES: Grape-extract resveratrol; GLP1: Glucagon-like peptide 1; HbA1c: Glycated hemoglobin; HDL: High Density Lipoprotein; HDL-cho: HDL-cholesterol; Hs-CRP: High sensitive-C Reactive Protein; IGF-1: Insulin like Growth-1 into Growth Factor-1; IGFBP3: Insulin like Growth Factor Binding Protein 3; IL-10: Interleukin-10; IL-6: Interleukin-6; LDL: Low Density Lipoproteins; LDL-cho: LDL-cholesterol; NAMPT: Nicotinamide phosphoribosyltransferase; NF- $\kappa$ B: Nuclear Factor  $\kappa$ -B; NO: Nitric Oxide; OFR: Oxygen Free Radicals; Ox-LDL: Oxidized-LDL; PAI-1: Plasminogen Activator Inhibitor-1; PBMCs: Peripheral Blood Mononuclear Cells; PGC1: Peroxisome proliferator activated receptor gamma coactivator 1; PPARGC1A: Peroxisome Proliferator Activated Receptor Gamma Coactivator 1 alpha; RASSF1a: Ras association domain-containing protein 1-alpha gene; RES: Resveratrol; SIRT1: Sirtuin 1; T2DM: Type 2 Diabetes Mellitus; TNF-alpha: Tumor Necrosis Factor-alpha; TRMs: Total Resveratrol Metabolites; UC: Ulcerative colitis; UF: Ultrafiltrate; URM: Urine Resveratrol Metabolites; wks: weeks

### KEYWORDS

Resveratrol; wine and health; oxidative stress; winemaking

### Introduction

It is well known that a healthy diet is one of the most potent tools to avoid any kind of malnutrition, as well as to reduce risk factors for chronic pathologies such as cancer, cardiovascular diseases, diabetes and dementia. A balanced diet must supply the suitable amount of energy and nutrients to maintain the desirable body weight and homeostasis. In this regard, several national and international guidelines have been published to guide the choices of consumers and public organizations (EFSA 2017; JECFA 2003; USDA 2015). In the last few decades, besides the nutritional

balance, a relatively new concept on the proper intake with the diet of functional compounds (for example antioxidants such as polyphenols) has been introduced; in fact, while not providing energy, they can contribute critically to the general health of consumers (Vanzour et al. 2010; Cvejic and Gojkovic-Bukarica 2016).

Aging and, consequently, chronic non-transmissible or lifestyle diseases such as cardiovascular diseases, diabetes, oncological and neurodegenerative diseases, start as functional problems many years before their clinical manifestations. Aging

**Table 1.** Antioxidant defense systems in intracellular, intravascular and intestinal lumen spaces.

Source of antioxidant defense	Specific molecule	Intracellular space	Intravascular space	Intestinal lumen
<i>Endogenous enzymes</i>	Catalase	X		
	Glutathione peroxidase	X		X
	Superoxide dismutase	X		
<i>Endogenous antioxidant</i>	Glutathione	X		
<i>Active molecules from food</i>	Carotenes	X	X	X
	Vitamin C	X	X	X
	Vitamin E	X	X	X
	Polyphenols	X	X	X

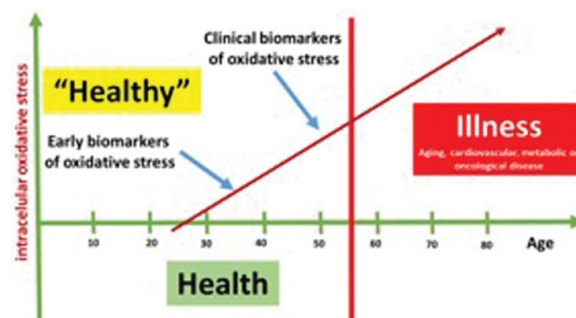
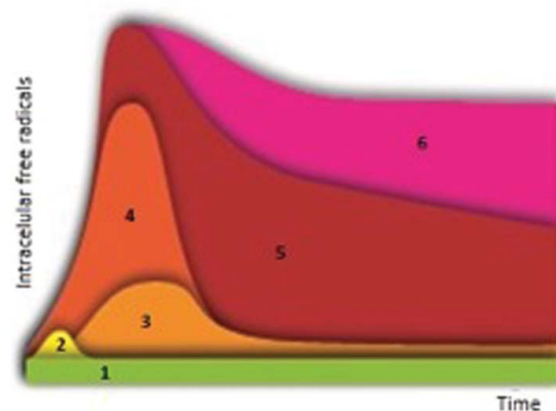
Modified from Boveris 2004.

as a concept of use and wear, as well as an accumulation of damages in molecular structures over time have a common denominator, namely, oxidative stress. Oxidative stress is an increase in free radical production and/or a decrease in the production of antioxidant molecules (Sies 1985; Hernández Saavedra and Mc Cord 2007; Pisoschi and Pop 2015). Cellular biology covers the energy demands of metabolism through organelles such as mitochondria. In order to accomplish this process, mitochondria, which can be considered as chemical machines, work at constant pressure and temperature to produce energy (adenosine triphosphate or ATP) 24 hours a day. As part of this energy production process, however, mitochondria also produce metabolic waste, that is, oxygen free radicals (OFR). One to three percent of the oxygen that cells breathe (which is equivalent to 4 to 12 liters of oxygen/day for humans) leaks from the respiratory mitochondrial chain, goes through their membrane and remains in the cell as OFR (Boveris et al. 1972), producing an accumulation of acid waste, molecular damages, diseases and aging (Boveris 2005; Raha and Robinson 2000). Therefore, mitochondria, the main source of cellular energy, are also the source of 95% of the body's OFR (Stotland and Gottlieb 2015). Correspondingly, evolving biology has adapted by means of a system of "antioxidant defense" inside the intracellular compartment to protect itself from damages caused by its own functioning (Table 1).

Unlike intracellular spaces, the antioxidant defenses of intravascular and intestinal lumen spaces depend almost exclusively on the food supply, which makes them vulnerable to oxidative stress if the supply is 'unsuitable'. In other words, the lifestyle-related prevention is greatly significant to fight the redox imbalance. As Table 1 shows, the intracellular antioxidant defense system is dual and based on endogenous enzymatic system and a non-enzymatic food-borne system. Eventually, the enzymatic system is defeated by the damage produced by OFR, causing an increase of oxidative stress (Sies 1985; Hernández Saavedra and McCord 2007; Pisoschi and Pop 2015). It has been shown that after 20 years of age, intracellular antioxidant defenses as measured by glutathione concentration start decreasing at approximately 1.2% per year due to OFR damage (Samiec et al. 1998; Maher 2005). Therefore, oxidative stress caused by OFR is the side-effect of energy production due to the comburent used, which is oxygen (Barja 2014). As shown in Figure 1, during human life, three stages can be potentially identified in redox homeostasis: the first one is 'full health' period, up to 28–30 years old, when antioxidant defenses are balanced in number with pro-oxidant

molecules. The second stage is the 'healthy' period (apparent wellbeing), between 30 and 60 years old, when there is a redox imbalance with oxidative stress produced by the deterioration associated with aging, being sedentary, overweight or obesity, an increased and unbalanced plasma cholesterol concentration, and physical or psychological stress. During this stage, the 'healthy' situation is relative due to redox imbalance and lifestyle-related prevention is greatly significant. After turning approximately 60 years old, a third stage begins called 'illness' period with possible clinical manifestations.

As shown in Figure 2, during this third stage (illness), total oxidative stress is the sum of what has been provided by cellular breathing (level 1), oxidative stress by physiological stimulation (e.g. postprandial) (level 2), metabolic waste and other

**Figure 1.** Oxidative stress snowball effect. Stages on redox homeostasis evolution in time. In (y) redox homeostasis in (x) years.**Figure 2.** Evolution of oxidative stress in time. 1) cellular breathing oxidative status average; 2) oxidative stress by physiological stimulation (e.g. postprandial); 3) and 4) acute to mild chronic oxidative stress; 5) acute to moderate chronic oxidative stress; 6) acute to severe chronic oxidative stress (Modified from Preiser 2012).

disease risk factors such as high blood pressure, obesity, dyslipoproteinemia, chronic inflammatory processes and diabetes mellitus (levels 3 to 6).

The measurement of the body's antioxidant defenses could become usual practice in the future to evaluate risk factors for chronic diseases, in addition to blood pressure and body weight. For example, a quantification of skin carotenoids by resonance Raman Spectroscopy has been suggested by Mayne et al. (2013). A decrease in antioxidant defenses may act as an alert to change dietary practices or to use antioxidant dietary supplements to reduce the risk of cardiovascular, metabolic or neurodegenerative diseases, as well as that of cancer. Non-invasive Raman Spectroscopy is a technique that can be used to measure antioxidant defenses (Ermakov and Gellerman 2010).

As cells do not have antioxidant reserves, if intestinal digestion causes oxidative stress and there is not an appropriate dietary antioxidant balance, the cellular structures of the internal milieu may be damaged (Rahal et al. 2014).

Potential benefits of drinking red wine with meals have been partly ascribed to wine's relatively large content of polyphenols such as resveratrol (Das and Das 2010). Polyphenols have been shown to reduce the damaging effects of OFR during food digestion and absorption (Karatzis et al. 2008). Nourishment may become a risky habit, therefore, if there is not an appropriate redox balance in nutrients.

## Resveratrol

Resveratrol (3, 5, 4'-trihydroxystilbene) is a phytoalexin, non-flavonoid polyphenol present in more than 70 plant species. Only a few of these plants are edible and among the latter, the most important are: *Vitis vinifera* (grape), *Arachis hypogaea* (peanut), *Theobroma cacao* (cacao), plants producing berries (*Vaccinium myrtillus*, *Ribes nigrum*, *Rubus idaeus*, etc.) and their relative by-products (such as red wine, chocolate, juices, etc.). It has been shown that resveratrol has *in vitro* anti-inflammatory effects and, accordingly, has been used as dietary supplement in animal models to increase longevity and improve health in mice fed with hypercaloric diet (Baur et al. 2006; Birrell et al. 2005; Rahman 2006). Dietary studies in animal models have shown that resveratrol and other chemically related compounds activate SIRT1 (Cantó and Auwerks 2012; Timmer et al. 2012), and imitate the effects of caloric restriction (Lee and Min 2013; Wu and Hsieh 2011); sirtuins are a family of deacetylase enzymes that, when activated, silence DNA information. The interest in resveratrol in nutrition and medicine started in 1992, when resveratrol was identified as a possible explanation for cardiovascular protective effects associated with the intake of red wine in "The French Paradox" (Siemann and Creasy 1992; Renaud and De Lorgeril 1992). One potential cardioprotective mechanism of action is the inhibition of low density lipoprotein (LDL) oxidation (Frankel et al. 1993; Frankel et al. 1995). Potential cancer preventive effects have also been proposed for resveratrol (Jang et al. 1997; Carter et al. 2014; Xue et al. 2014). Such data increased the interest of scientists, the general public and the pharmaceutical and dietary supplement industries, so that a bibliographic search in Pubmed using 'resveratrol' as the keyword currently delivers more than 9,000 publications.

Numerous research efforts explored resveratrol's biological mechanisms of action. There are, however, certain limitations that create doubts when extrapolating the results of basic *in vitro* and *ex vivo* research to human health. For example, basic research often involves dietary interventions with relatively high doses of resveratrol compared to those naturally found in wine (Lin et al. 2016; Wong et al. 2016).

It is well known that the food matrix is important in modifying intestinal absorption, bioavailability, pharmacokinetics of molecules and, as a consequence, animal and human health outcomes (Stockley et al. 2012). In general, lipophilic resveratrol has been shown to be highly absorbed after oral ingestion and extensively and rapidly metabolised through glucuronidation and sulfation reactions in the liver, and also through hydrogenation of the aliphatic double bond in the intestine (Soleas et al. 2001; Meng et al. 2004; Goldberg et al. 2003; Walle et al. 2004). Human studies by Walle et al. (2004) on the oral absorption of <sup>14</sup>C-resveratrol showed that the elimination half-life of total resveratrol metabolites is about 6 to 15 hours after oral doses. Resveratrol metabolites can be detected in the urine of humans consuming one glass of wine per week, if the last drink was consumed three days previously, or in those consuming three glasses of wine per week, if the last drink was consumed five days previously (Zamora-Ros et al. 2006; Zamora-Ros et al. 2009).

Despite its rapid biotransformation, resveratrol may show efficacy *in vivo* through its metabolites or derivatives (Stockley et al. 2012). In plasma, unmetabolised resveratrol binds to both albumin and lipoproteins such as LDL (Gambini et al. 2015). These complexes, in turn, can be dissociated at cellular membranes, which have receptors for albumin and LDL, leaving the resveratrol free and allowing it to enter cells. Accordingly, resveratrol may interact with extracellular and intracellular molecules, and its mechanism of action at the cellular level may be triggered by either activating signaling pathways, when binding to cell membrane receptors, activating intracellular mechanisms, or even developing its effects inside the nucleus. In addition, its efficacy may also be explained by the conversion of both sulfates and glucuronides back to resveratrol in target organs, such as the liver and intestine (Vitrac et al. 2003; Wenzel and Somoza 2005). In addition, *in vivo* effects may be attributable to its bioactive metabolites, which are measurable in plasma and urine post oral ingestion (Vitaglione et al. 2005; Boocock et al. 2007).

## Resveratrol daily intake

Different studies have calculated the daily dietary intake of resveratrol or total stilbenes, but results are not always in agreement (Rabassa et al. 2015; Siemann and Creasy 1992; Zamora-Ros et al. 2006; Zamora-Ros et al. 2008; Zamora-Ros et al. 2009; Zamora-Ros et al. 2012). According to a relatively recent study (Rabassa et al. 2015), the daily intake of total resveratrol (total stilbenes) is in the order of few mg/day, where red wine is the richest source (approximately 90%).

## Resveratrol and human health: Criteria for literature search

In this review, papers reporting human studies on resveratrol intake and benefits are collected and discussed, according to



the body of evidence. Two of the most important scientific databases of references and abstracts on life sciences and biomedical topics, PubMed/MEDLINE and Embase, were systematically searched to create the present work. The following search strategy and selection criteria were used: data were collected from database inception to April 2017, with the terms “clinical trial”, “benefits”, “health”, in combination with “resveratrol”. Additional search criteria were: human study; oral exposure; and controlled trial.

## Results

Since 2009, there has been a proliferation of resveratrol-related dietary interventions in patients treated for different pathologies and in healthy volunteers with risk factors. Searches from 1970 to 2008 produced mainly studies performed *in vitro* or in laboratory animals. The papers selected according to the inclusion criteria are listed in Table 2.

The Spanish PREDIMED study was one of the first studies to assess the association between moderate wine consumption, resveratrol intake and cardiovascular (CVD) risk factors in 1000 participants including high cardiovascular risk patients (Zamora-Ros et al. 2012). Measuring the total resveratrol metabolites (TRMs) in urine as biomarkers of exposure, the authors showed that moderate wine consumption as well as resveratrol intake can positively modulate some recognized CVD risk factors, such as blood lipid profiles, fasting blood glucose (significant changes only with resveratrol) and heart rate. Data collected indicated that resveratrol intake (as such or with wine) might help to decrease CVD risk factors.

A second study by Semba et al. (2014), assessed whether dietary resveratrol intake, but not specifically wine consumption, modulated events associated with inflammation, CVD, cancer and mortality. It was a prospective cohort study involving 783 community-dwelling men and women aged 65 years or older in two villages of the Chianti area, from 1998 to 2009. Urines were analysed to measure the level of resveratrol metabolites (URM), and population was classified in quartiles: <1554 (n = 195), 1554–4996 (n = 196), 4996–15010 (n = 196), and >15010 (n = 196) nmol URM/g creatinine. During the nine years of follow-up, 268 (34.2%) of the participants died. The relationship between URM and all-cause of mortality was statistically evaluated and no significant correlation was found, when the model was adjusted for age, sex, BMI, serum level of lipids, and chronic diseases. In details, no differences was observed between quartiles for heart failure, peripheral artery disease, stroke, diabetes mellitus, cancer, chronic kidney disease, and overall mortality.

To better evaluate the result of the study, the authors calculated the average daily dietary consumption of resveratrol in this population during the follow up. The mean log dietary intake of resveratrol (mg) were: −2.71 (−2.87 to −2.55) at 3 months; −2.82 (−2.99 to −2.64) at 6 months; and −2.66 (−2.81 to −2.50) at 9 months. This amount appeared insufficient to have a significant influence on health status and mortality risk of participants. Moreover, the lack of the expected association may reflect variability in resveratrol intake, inter-individual variation, and variability of host-gut microbiota

(Blaut and Clavell 2007; Nicholson et al. 2012) indicating that a much larger sample size is required to reach final conclusions.

These contradictory studies, therefore, suggest that the next research step is the identification of an effective ‘dose’ of resveratrol necessary to benefit human health. Summarizing the data collected in this review (Table 3 and 4), the most significant beneficial health effects are associated with the cardiovascular system. The lowest active amount of resveratrol identified was 30 mg/day to improve endothelial function in healthy individuals (Wong et al. 2011). A wide range of resveratrol ‘doses’ has been associated with the improvement of other physiological/pathological functions and parameters or reduction of risk factors.

## The effects of viticulture and winemaking practices on resveratrol concentrations in wine

Resveratrol exists in both *cis* and *trans* forms in wine, but *trans*-resveratrol predominates in grapes and may be methylated and polymerized to produce piceid, pterostilbene and the viniferins, respectively, and glycosylated during fermentation (Jeandet et al. 1995a; Langcake 1981; Pezet and Cuenat 1996). The average concentration of total resveratrol in red wine is 7 mg/L and is 2 mg/L in rosé and 0.5 mg/L in white wine, but ranges widely according to grape variety, geographical indication and vintage (Waterhouse 2002). In contrast to other grape-derived phenolic compounds produced in the skins and seeds of grapes in response to increased sunlight and temperature (Spayd and Tarara 2002), resveratrol acts like a phytoalexin and is produced by the skin cells of grapes and by the leaves in response to *Botrytis cinerea*, *Plasmopara viticola*, *Rhizopus stolonifer*, *Uncinula necator* and other fungal infections on grapevines, as well as in response to UV light, radiation and related external stimuli (Ector et al. 1996; Adrian 2000; Gerschman et al. 1954). Resveratrol is also synthesized by unstressed vines but to a significantly lesser degree (Pezet et al. 1996). Disease-resistant plant genotypes quickly produce and accumulate resveratrol while in susceptible species, such as *Vitis vinifera*, production occurs more slowly. The cultivar Pinot Noir appears quite susceptible to fungal infection and hence generally produces and accumulates a higher concentration of resveratrol than other varieties, irrespective of viticultural origin (Siemann and Creasy 1992; Goldberg et al. 1995; Jeandet et al. 1995b).

Accordingly, a high concentration of resveratrol has been consistently measured in wines from cooler climate regions reflecting a cool damp climate and increased fungal pressure, such as Ontario in Canada, and Bordeaux and the Rhone Valley in France, although some sub-regional differences were also observed (Goldberg et al. 1995; Soleas et al. 1997). Conversely, a significantly lower concentration of resveratrol has been measured in wines from relatively warm and dry climates. In grape berries infected with powdery mildew, however, the concentration of resveratrol appears to be correlated with the fungal pressure (Romero-Perez et al. 2001). Studies suggest also that although the synthesis of resveratrol is induced and increases as climatic conditions lead to *Botrytis cinerea* infection, excessively heavy infection actually degrades the induced resveratrol by activating an exocellular laccase-like stilbene oxidase, so that a relatively low concentration of resveratrol is measured in

**Table 2.** Overview of selected studies regarding resveratrol-related dietary interventions from 1970 to 2016.

	Cohort, sample size (n)	Trial type	Resveratrol dosage	Duration	Target	Main outcome	Reference
1	Patients with colon cancer (n = 8).	Four parallel arms, randomized trial. Uncontrolled and open trial.	Daily intake of: 80 g grape powder (GP) with 0.07 mg RES, n = 3; or 120 g GP with 0.11 mg RES, n = 2; or 3.9 mg RES + 120 mg quercetin, n = 2; or 15.5 mg RES + 480 mg quercetin, n = 1.	19 days	Changes in Wnt signalling pathway in normal and cancer colon tissues after surgery.	Inhibition of some genes from Wnt signalling pathway only in normal tissue.	Nguyen et al. 2009
2	Patients with colorectal cancer (n = 20).	Two parallel arms, non-randomized, blind, placebo uncontrolled.	RES daily dose: 0.5 g, n = 10; or 1 g, n = 10. RES in capsules.	8 days	Detection of RES and metabolites in colorectal tissue, and effect on proliferation marker Ki-67.	Ki-67 antigen level was reduced by 5% and 7% in cancer and normal tissue, respectively.	Patel et al. 2010
3	Patients with colorectal cancer and hepatic metastasis (n = 6).	Two parallel arms, randomized, placebo controlled.	Preoperative daily intake of a sachet containing 5 g of RES or placebo.	From 10 to 21 days	Pharmacokinetics, tissue disposition and effect on apoptosis marker (cleaved caspase-3).	Detection of RES in hepatic tissue and increased (39%) content of cleaved caspase-3 in this tissue.	Howells et al. 2011
4	Twenty overweight or obese male subjects (age: 36.6–61 yrs) with non-alcoholic fatty liver disease.	Open study, placebo-controlled.	Placebo or 3000 mg RES daily. Daily dose: 3 cps (500 mg) before breakfast and before bedtime (total 6 cps). They were instructed to maintain their lifestyle habits.	8 weeks	To determine if RES improves the parameters of non-alcoholic fatty liver disease.	RES was well tolerated, although there were no significant results in insulin function, steatosis, or abdominal fat distribution. There were no changes in plasma markers of inflammation.	Chachay et al. 2014
5	60 subjects with non alcoholic fatty liver disease.	Double-blind, randomized, placebo-controlled trial.	Subjects were given placebo or 2 cps containing 150 mg RES, twice daily.	3 months	To evaluate the effect of RES on insulin resistance, glucose, hepatic enzymes and lipid metabolism in nonalcoholic fatty liver disease.	RES significantly decreased aspartate aminotransferase, glucose and LDL cholesterol.	Chen et al. 2015
6	49 patients (15 females) with a history of non alcoholic fatty liver disease. Mean age of 45.16.	Randomized, double-blinded, placebo-controlled.	Placebo or 500 mg/day of RES.	12 weeks	To determine the effect of RES supplementation on liver enzymes and inflammatory markers in patients with nonalcoholic fatty liver disease.	Significant decreases in both groups in circulating and liver inflammatory markers, and ALT levels in response to RES.	Faghizadeh et al. 2014
7	Patients on statin treatment and at high risk of CVD (n = 75).	Three parallel arms, randomized, triple blind, placebo controlled trial.	Follow-up: daily ingestion of 350 mg of 1) placebo (n = 25), or 2) grape extract (GE) (n = 25), or 3) GE + 8 mg RES, (n = 25). Product in capsules.	6 months	Effects on atherogenic markers, i.e. serum lipid profile, Apo B and oxLDL.	GE-RES decreased LDL-cholesterol (4.5%); Apo B (9.8%) and oxLDL (20%), while GE determined only a significant decrease of LDL-cholesterol (2.9%). No drug interaction was detected.	Tomé-Carneiro et al. 2012a

(continued on next page)

Table 2. (Continued)

	Cohort, sample size (n)	Trial type	Resveratrol dosage	Duration	Target	Main outcome	Reference
8	Post-infarction patients (n = 40).	Randomized, 2 parallel arms, double-blind, placebo controlled trial.	Follow up: daily ingestion of 10 mg RES (n = 20) versus placebo (n = 20). RES in capsules.	3 months	Measure of biomarkers for cardioprotection.	RES decreased LDL-cholesterol (8%), improved endothelial function (50%), and left ventricular diastolic function (2%). No effect on inflammatory parameters (CRP and TNF- $\alpha$ ).	Magyar et al. 2012
9	Patients on statin treatment and at high risk of CVD (n = 75). (Same cohort as in Tomé-Carneiro <i>et al.</i> 2012a).	Three parallel arms, randomized, triple blind, dose-response, placebo-controlled trial.	Follow-up: daily ingestion for 6 months of 350 mg of 1) placebo (n = 25), or 2) grape extract (GE) (n = 25), or 3) GE + 8 mg RES, (n = 25). Further treatment for 6 months with a double dose. Products in capsules.	12 months	Effect on inflammatory and fibrinolytic status of patients.	GE-RES decreased hs CRP (−26%), TNF- $\alpha$ (−19.8%), PAI-1 (−16.8%) and IL-6/IL-10 ratio (−24%), and increased IL-10 (19.8%). No drug interaction was found.	Tomé-Carneiro et al. 2012b
10	Patients with stable angina pectoris (n = 116).	Randomized, double-blind, active-controlled.	Follow up: oral supplementation with calcium fructoborate (CF) (112 mg/day), or RES (20 mg/day), or their combination.	60 days	Effect on inflammation biomarkers (hs CRP), left ventricular function markers (N-terminal pro-hormone of brain natriuretic peptide – BNP), and lipid markers (total cholesterol, LDL-cholesterol, HDL-cholesterol, and triacylglycerols).	Significant hs CRP decrease in all groups: 39.7% in the CF group; 30.3% in RES plus CF group. The N-terminal pro-hormone of BNP was significantly lowered by RES (59.7% at 60 d) and by CF (52.6% at 60 d). However, their combination was the most effective and induced a decrease of 65.5%.	Militaru et al. 2013
11	Patients with stable CAD (n = 75).	Three parallel arms, randomized, triple-blind, dose response, placebo-controlled trial.	Follow-up: daily ingestion of 350 mg placebo (n = 25), grape extract without (GE) (n = 25); or with 8 mg RES (GE-RES), n = 25) for 6 months, and the double dose for the following 6 months.	12 months	Effect on inflammatory and fibrinolytic status of patients.	Lipid markers showed no significant changes from baseline in all groups. Significant increase in adiponectin levels (10%) in GE-RES group in addition to a decrease in PAI-1 levels. Non-HDL cholesterol decreased significantly in both GE and GE-RES groups. Downregulation of pro-inflammatory genes expression in PBMCs isolated from GE-RES group patients.	Tomé-Carneiro et al. 2013a

12	35 adult hypertensive men with a mean age of 60±11 years previously diagnosed with Type 2 diabetes (T2DM).	Three parallel arms, randomized, triple-blind, dose response, placebo-controlled trial.	Daily intake of grape extract vs. RES-supplemented grape extract (8.1 ± 0.5 mg RES per capsule) for 6 months and double dose for the next 6 months.	12 months	To investigate the molecular changes in peripheral mononuclear cells in hypertensive patients with T2DM.	Some cytokines were down-regulated, such as CCL3 and TNF- $\alpha$ ; RES modulated the expression of micro RNAs involved in the inflammatory response, including miR663 and miR-30c2.	Tomé-Carneiro et al. 2013b
13	19 men with a diagnosis of schizophrenia (18–65 yrs old) overweight or obese and/or with metabolic disorders.	Randomized, double-blind, controlled trial.	The participants received a diet prescription one month before starting the study, then they received placebo or RES (200 mg/day) per 4 weeks.	2 months	To determine the efficacy of RES on serum glucose and CVD risk factors.	No change in body weight, waist circumference, serum glucose and cholesterol in the RES group.  Changes in the lipid profile. In the placebo group, there was a significant increase in total cholesterol, LDL-cholesterol and in triglycerides, as well as a reduction in HDL-cholesterol.	Zortea et al. 2016
14	Patients with metabolic syndrome (n = 34).	Randomized, cross-over, open trial.	Group A (n = 17): Treatment with 100 mg RES in capsules for 3 months followed by 3 months with placebo. The inverse pattern in group B, n = 17.	6 months	Evaluation of several parameters in patients with metabolic syndrome.	In both groups, Flow-Mediated-Dilatation (FMD) improved from 4% to 10% and returned to baseline values after discontinuation of RES treatment. No effect was observed on other inflammatory and atherogenic biomarkers.	Fujitaka et al. 2011
15	24 patients previously diagnosed with metabolic syndrome (30–50 yrs; sex not indicated).	Randomized, double-blinded, placebo-controlled.	Placebo or 500 mg RES 3 times a day, before meals.	90 days	To investigate the effect of RES on insulin release and efficacy in patients with metabolic syndrome.	In the RES group, there were significant reductions in total weight, BMI, fat mass, and waist circumference. There were also significant differences in insulin sensitivity.	Mendez del Villar et al. 2014
16	Type 2 male diabetic patients (n = 19).	Two parallel arms, randomized, double blind, placebo controlled trial.	Daily ingestion of 10 mg RES, n = 10 or placebo, n = 9. RES in capsules.	4 weeks	Effect on insulin resistance.	Decrease of insulin resistance possibly due to a reduction of oxidative stress, as shown by measuring urine and platelet biomarkers.	Brasnyó et al. 2011.

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Table 2. (Continued)

	Cohort, sample size (n)	Trial type	Resveratrol dosage	Duration	Target	Main outcome	Reference
17	Type 2 diabetics (n = 62).	Randomized trial, placebo-uncontrolled, open, 2 parallel arms.	Daily ingestion of hypoglycemic drugs + 250 mg RES (n = 28) or only hypoglycemic drugs in control group (n = 29). Products in capsules.	3 months	Effects on glycemic control and associated risk markers.	RES significantly improved concentration of: fasting glycemia (−14.4%); systolic (−11.8%), and diastolic (−2.1%) blood pressures, HbA1c (−0.3%), total cholesterol (−14.3%), and LDL-cholesterol (−12.5%); urea-nitrogen (−3.23%); improved insulin sensitivity and postmeal plasma glycemia. No change in fasting glycemia. No dose-response.	Bhatt et al. 2012.
18	Overweight/obese and moderately insulin resistant older adults (n = 10).	Randomized, placebo-uncontrolled, open-label trial.	RES capsules in one of the three doses: 1, 1.5, and 2 g/day.	4 weeks	Glucose metabolism and vascular function.	Improved insulin sensitivity and postmeal plasma glycemia. No change in fasting glycemia. No dose-response.	Crandall et al. 2012.
19	45 patients with diet-controlled type-2 diabetes.	Double-blind, randomized, crossover design.	Patients received RES (500 mg twice daily) or placebo over two 5 wks intervention periods with a 5 wks washout, and then cross-over.	15 weeks	To evaluate the effects of 5 wks of RES treatment on GLP-1 (glucagon-like peptide 1) secretion, gastric emptying, and glycemic control in type-2 diabetes.	No significant change in both groups for any parameter measured.	Thazhath et al. 2016.
20	10 males with Type 2 diabetes mellitus (40–69 yrs old).	Randomized, double-blind, placebo controlled trial.	Subjects were given a starting dose of 500 mg daily of either RES or placebo associated with a RES-free diet. The dose was increased by 500 mg/day every 3 days to a maximum dose of 3 g/day. Doses were divided in three administrations.	15 days	To assess the effect of RES on skeletal muscle SIRT1 expression and energy expenditure.	In patients with T2DM, the treatment with RES regulates energy expenditure through increased levels of skeletal muscle SIRT1 and AMPK expression. These findings indicate that RES may have beneficial exercise-mimetic effects in patients with T2DM.	Goh et al. 2014.
21	Patients with Alzheimer Diseases (n = 119).	Two parallel arms, randomized, placebo controlled trial.	Participants received placebo or resveratrol 500 mg orally once daily (with dose escalation by 500-mg increments every 13 weeks, ending with 1,000 mg twice daily).	39 weeks	Penetration of resveratrol and its major metabolites into the blood–brain barrier to have CNS effects.	RES penetrates into cerebral spinal fluid and positively modulates biomarkers of Alzheimer disease. Further in-depth studies are suggested.	Turner et al. 2015.

22	80 post-menopausal women (45–85 yrs).	Randomized, double-blind, placebo-controlled trial.	Two capsules of RES (75 mg/day).	14 weeks	To determine the effects of RES on cognition, cerebrovascular responsiveness to cognitive tasks and overall well-being.	According to the results of tests, RES, as other vasoactive nutrients, could enhance mood and cognition and reduce the risk of developing dementia in post-menopausal women and other at-risk populations.	Evans et al. 2016.
23	72 patients with peritoneal dialysis (PD); 8 drop out.	Double-blind, placebo-controlled, and randomized trial.	Patients received placebo (n = 24) or trans-RES 150 mg/day (n = 22) or 450 mg/day (n = 18).	12-weeks	To evaluate effects on angiogenesis-related markers.	Over the 12-week period, patients in the high-dose group showed a significant improvement in mean net Ultrafiltration (UF) volume and UF rate.	Lin et al. 2016.
24	Patients taking an oral contraceptive (n = 12 + n = 42).	Unmasked and unrandomized trial.	Two separate experiments: 1) 2 months with 30 mg of RES in addition to oral contraceptive (3 mg drospiredone and 30 mg ethinylestadiol) previously taken for 6 months; 2) Sixteen patients on oral contraceptives alone and 26 with addition of RES for at least 2 months prior to hospital admission.	2 months	Experiment 1: Effect on endometriosis related pain Experiment 2: Effect on aromatase and cyclooxygenase-2 expression in endometrial tissue.	RES significantly reduced pain scores (82% of patients reporting complete resolution of dysmenorrhea and pelvic pain after 2 months of use). Inhibition of both aromatase and cyclooxygenase-2 expression was significantly greater in the eutopic endometrium of patients taking RES compared with oral contraceptives alone.	Maia et al. 2012.
25	56 patients with active mild to moderate ulcerative colitis (UC).	Randomized, double-blind, placebo-controlled trial.	Patients received 500-mg RES or placebo.	6 weeks	To evaluate the RES properties as an anti inflammatory and antioxidant agent. Effect on quality of life.	RES significantly reduced plasma levels of TNF- $\alpha$ , and activity of NF- $\kappa$ B, in PBMCs.	Samsamikor et al. 2016
26	Eight overweight or obese individuals (28–55 yrs old) with a history of hypertriglyceridemia.	Randomized, double-blind, placebo-controlled trial.	One g RES daily during 1st week, then 2 g daily during 2nd week.	2 weeks	To evaluate turnover of intestinal and hepatic lipoprotein (ApoB-48 and ApoB-100), whose high levels are markers of atherosclerosis, heart disease and other CVD.	RES decreased production of ApoB-48 and ApoB-100 by 22 and 27%, respectively. No difference in insulin sensitivity, fasting triglycerides, plasma cholesterol, or HDL-cholesterol.	Dash et al. 2013
27	Healthy overweight/ obese men or post-menopausal women with mildly elevated blood pressure (n = 19).	Randomized, crossover, double blind, single dose, placebo-controlled trial.	Single ingestion of 30, 90, 270 mg of synthetic RES or placebo at weekly intervals. Analyses were performed 1 h after consumption of the product (capsules).	Three acute doses	Acute, dose dependent effect of RES on Flow Mediated Dilatation (FMD), marker of endothelial function.	FMD improved by 65% 1 h after consuming 30 or 90 mg RES and by 88% with 270 mg RES.	Wong et al. 2011

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Table 2. (Continued)

	Cohort, sample size (n)	Trial type	Resveratrol dosage	Duration	Target	Main outcome	Reference
28	Healthy adult smokers (n = 50).	Randomized, double-blind, placebo-controlled, cross-over trial.	Follow up: patients were allocated to either "resveratrol-first" group (30 days of 500 mg RES/day, 30 days wash-out, 30-days placebo) or to "placebo-first" group (30 days placebo, 30 days wash-out, 30 days 500 mg RES/day).	90 days	Effects on markers of inflammation and oxidative stress in smokers.	Significant CRP and triglyceride concentrations reduction, and increased Total Antioxidant Status values. No significant change in serum uric acid, glucose, insulin, cholesterol, liver enzyme concentrations, and body weight, waist circumference, and blood pressure.	Bo et al. 2013
29	27 aged physically inactive and non-smokers males (60–72 yrs old).	Randomized, double-blind, placebo-controlled trial.	Subjects were allocated to either a combination of exercise training and placebo or exercise training and 250 mg day of trans-RES.	8 weeks	To evaluate if RES further enhances training-induced improvements in cardiovascular health parameters in aged men.	The major findings were that 8 weeks of exercise training induced a number of beneficial cardiovascular effects, but parallel supplementation with resveratrol reduced several of these improvements.	Gilemann et al. 2013
30	11 obese "healthy" men (40–65 yrs old).	Randomized, double-blind, cross-over trial.	150 mg daily of placebo or RES for 30 consecutive days. 4-week washout period and then cross-over treatment.	90 days	To investigate a 30-day intake of RES on adipose tissue morphology.	RES significantly reduced adipocyte size, which may contribute to the improvement in insulin sensitivity.	Konings et al. 2014
31	10 obese "healthy" men with a mean age of 52±2.	Randomized, double-blind, cross-over trial.	A 4 week washout period was followed by 30 days of RES administration (150 mg daily) without other polyphenol consumed.	2 months	To investigate postprandial incretin hormone levels and glucagon responses.	RES had no effect on postprandial incretin hormone responses, but showed a significant effect in suppressing postprandial glucagon response.	Knop et al. 2013
32	32 overweight "healthy" adults (60–80 yrs old; 16 women). Under no medication.	Randomized, double-blind, placebo-controlled trial.	Daily intake of placebo or 300 or 1000 mg RES, taken in two doses, immediately following breakfast and dinner.	12 weeks	To determine safety and metabolic outcomes of RES supplementation in older adults.	RSV was generally well tolerated. RES (two positions) decreased fasting glucose and bilirubin levels.	Anton et al. 2014

33	Nonobese, post-menopausal women (n = 45).	Randomized, double-blind, placebo-controlled trial.	75 mg/day of RES.	12 weeks	Evaluate the metabolic effects in nonobese, post-menopausal women with normal glucose tolerance.	No change in body composition, resting metabolic rate, plasma lipids, or inflammatory markers. No increase in liver, skeletal muscle, or adipose tissue insulin sensitivity. No effect in RES putative molecular targets, including AMPK, SIRT1, NAMPT, and PPARGC1A, in either skeletal muscle or adipose tissue.	Yoshino et al. 2012
34	Obese "healthy" men (n = 24).	Randomized, placebo-controlled, double-blind, and 2-arms.	Daily intake of three times/day of RES (500 mg) or placebo.	4 weeks	Metabolic effects of RES in obese subjects.	No significant change in insulin sensitivity in both groups. Endogenous glucose production and the turnover and oxidation rates of glucose remained unchanged. No effect on blood pressure, resting energy expenditure, oxidation rates of lipid, ectopic or visceral fat content, or in inflammatory and metabolic biomarkers.	Poulsen et al. 2013.
35	40 healthy post-menopausal women (50–66 yrs old), with an average BMI of 32.9 kg/m <sup>2</sup> .	Open trial.	Two tablets containing 500 mg RES daily. Restriction in foods containing polyphenols was required two weeks before and during the trial.	12 weeks	To evaluate if RES has a role in systemic sex hormone levels and estrogen metabolites in post-menopausal women to reduce risk factors for breast cancer.	RES intervention did not result in significant changes in sex hormone levels, but did result in a significant increase in sex-hormone binding globulin.	Chow et al. 2014
36	Healthy subjects (n = 40).	Open trial, blinded for analysis.	Daily ingestion of 0.5 g (n = 10), 1 g (n = 10), 2.5 g (n = 10) and 5 g (n = 10) micronized RES in capsules.	29 days	Evaluation of safety, pharmacokinetics and effects on circulating IGF-1 and IGFBP-3, which are involved in chemioprevention.	IGF-1 levels were decreased on the 2.5 g dose and IGFBP-3 on the 1 and 2.5 g doses. No linear dose-response was observed between RES plasma AUC values and effects on IGF-1 and IGFBP-3.	Brown et al. 2010
37	Women at higher breast cancer risk (n = 31).	Randomized, 3-arm, double-blind, placebo-controlled trial.	Daily ingestion of placebo, 5 mg or 50 mg RES in capsules.	3 months	Effects on DNA methylation and prostaglandin E2.	No significant effect on the 4 genes studied (RASSF-1a, APC, CCND2 and p16). A correlation was found between the decrease of RASSF-1a methylation and serum RES concentration.	Zhu et al. 2012

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Table 2. (Continued)

	Cohort, sample size (n)	Trial type	Resveratrol dosage	Duration	Target	Main outcome	Reference
38	16 healthy male, mean age of 22 years, performing 3 days/week of high intensity training. Unspecified medication, if any.	Randomized, double-blind, placebo-controlled trial.	Daily intake of placebo or 150 mg RES. Subjects were informed to refrain from consuming foods and drinks containing polyphenols for the duration of the study. No nutritional supplement allowed.	4 weeks	To investigate the effects of RES in high-intensity training.	RES did not affect aerobic or anaerobic capacity, or exercise substrate utilization, during training.	Scribbans et al. 2014
39	42 healthy but physically inactive men (60–72 yrs old).	Randomized, double-blind, placebo controlled trial.	Subjects from the first part were assigned to either a combination of exercise training with placebo or 250 mg RES/day.	8 weeks	To investigate the effects of RES alone and combined with exercise training on metabolic and inflammatory status in skeletal muscle.	Exercise training markedly increased muscle endurance and the content and activity of oxidative proteins as well as decreased the TNF $\alpha$ mRNA content and protein carbonylation level in skeletal muscle, which are involved in inflammation and oxidative stress. RES did not affect these parameters.	Olensen et al. 2014
40	13 healthy, sedentary adults (18–65 yrs old).	Randomized, double-blind, placebo controlled, crossover trial.	RES and placebo were administered twice daily. Regarding RES, the dose in the first week, was 500 mg (x2). This was increased to 1000 mg (x2) for the remaining 3 weeks if tolerated by the patient. Then there were two weeks of wash-out and cross-over. Daily ingestion of 150 mg of synthetic RES in capsules.	10 weeks	To assess the effect of RES on exercise capacity.	RES did not show any significant effect on exercise capacity or any other exercise parameters.	Voduc et al. 2014
41	Obese men (n = 11).	Randomized, crossover, double-blind, placebo-controlled trial.	Daily ingestion of 150 mg of synthetic RES in capsules.	1 month	To assess whether RES induces metabolic changes in obese men.	RES induced modest but consistent metabolic changes that mimic caloric restriction, such as reduction of sleeping and resting metabolic rate, activation of AMPK and increase of SIRT1 and PGC-1 in muscle, and others.	Timmers et al. 2011
42	Healthy subjects (n = 22).	Randomized, crossover, double-blind, dose-response, placebo-controlled trial.	Single intake of placebo, 250 mg or 500 mg RES in capsules. Analyses were performed 45 min after the ingestion. Cohort with a single arm to evaluate effects upon daily ingestion of 1 g RES in capsules.	Acute dose	Acute effect on brain functions by improving blood flow.	RES increased dose-dependently cerebral blood flow. Cognitive function was not affected.	Kennedy et al. 2010
43	Healthy subjects (n = 42).	Open Trial.		4 weeks	Effect of RES on CYPs and phase II enzymes.	RES inhibited the activity of CYP3A4, CYP2D6, and CYP2C9 and induced CYP1A2, with possible	Chow et al. 2010



44	74 middle aged obese men (41.8–56.8 yrs old), with metabolic syndrome. 8 drop out.	Randomized, double-blind, placebo-controlled trial.	Placebo or intake of 500 mg/day, or 75 mg of RES twice daily. Participants were instructed to avoid nutritional supplements during the study.	16 weeks	To evaluate the effects of RES on bone turnover markers, bone mass and structure.	effect on drug metabolism. Bone density increased in a dose-dependent manner by stimulating bone mineralization.	Ornstrup et al. 2014
45	10 healthy male volunteers (21–28 yrs old).	Randomized open trial.	One single 5 g dose of RES. Subjects received a standard diet not containing polyphenols during the study period.	48 hours	To determine the effect of RES on human mononuclear cells upon bacterial stimulation.	RES-treated individuals showed an increase in TNF- $\alpha$ levels after a 24-h treatment while IL-10 levels decreased. In this study, RES shows anti-inflammatory and immunomodulant properties.	Gualdoni et al. 2014

**Table 3.** Summary of resveratrol's effects in humans with different diseases.

Area	No. of studies (Ref. to Table 1)	Daily dose range (Lowest active dose)	Comments
Cancer	3 (1–3)	0.07–5 g (0.07 g)	Positive effects on markers of cellular proliferation, migration and apoptosis.
Fatty liver	3 (4–6)	0.3–3 g (0.3 g)	Reduction of hepatic enzymes and opposing results on inflammatory markers.
CVD	7 (7–12)	0.5–200 mg (0.5 mg)	In most studies, reduction of LDL-cholesterol ( $\geq 8$ mg) and some inflammatory markers ( $\geq 0.5$ mg).
Metabolic syndrome	3 (13–15)	0.1–1.5 g (1.5 g)	No significant effects on flow mediated dilatation till 0.1 g/day. Positive modulation of metabolic syndrome parameters at 1.5 g/day.
Diabetes	5 (16–20)	0.01–3 g (0.01 g)	Most studies showed improvement of insuline sensitivity; contradictory results in reduction of glycemia.
Cognitive functions	2 (21–22)	0.075–2 g (0.075 g)	General improvement of cognitive fuctions requiring further research to be confirmed.
Other	3 (23–25)	0.03–0.5 g	Reduction of pain score in women with dysmenorrhea (30 mg/day) and improvement of inflammatory biomarkers in ulcerative colitis (500 mg/day). Improvement in mean net ultrafiltration volume and rate in dialized patients ( $\geq 450$ mg/day).

wines from a vintage where there is heavy *Botrytis cinerea* pressure (Pezet et al. 1991; Jeandet et al. 1995b).

In nutraceutical research, ultrasonication techniques have been applied to enhance the accumulation of secondary metabolites in plants. Ultrasonication techniques have recently been applied to increase the accumulation of resveratrol in grape skins and leaves (Hasan and Baek 2013). The accumulation of resveratrol increased in grape skin by 7.7-fold after ultrasonication treatment for 5 minutes, followed by incubation for a further 6 hours. The increase of resveratrol in leaves, however, was less than that in grape skin. The amount of increased resveratrol in grape leaves after 15 minutes of ultrasonication, followed by a 3-hour incubation, was 1.8-fold higher than that observed in non-treated controls. The accumulation of resveratrol in both grape skin and leaves was dependent on the ultrasonication time and the incubation period. Resveratrol-enriched grape juice has also been obtained using ultrasonication treatment reported in previous work (Hasan et al. 2014). In all the grape varieties used, significantly higher amounts of resveratrol were observed in grape juice manufactured from fruit treated with ultrasonication of the grape skins of cultivars Campbell Early, MBA, and Kyoho: the content of resveratrol in juices increased by 1.53, 1.15, and 1.24 times, respectively.

The concentration of phenolic compounds in wine is also influenced by winemaking variable (Revilla et al. 2001). The extraction of total phenolic compounds during winemaking from the skins, seeds and flesh of grape berries into must, however, rarely exceeds 50% of the total amount present originally in the grape (Somers and Vétette 1988). In general, white wine is made by fermenting juice from which grape skins and seeds have been removed, and red wine is made by fermenting juice in the presence of grape skins and seeds. Fermentation with solid grape material allows the aqueous and alcoholic extraction of phenolic compounds from the skins and seeds. The concentration of total phenolic compounds in wine consequently increases during fermentation with skins and seeds, but may subsequently decrease as some of the phenolic compounds combine with proteins and yeast hulls and precipitate. The concentration of total phenolic compounds continues to decrease with fining and filtration, and during maturation.

As phenolic compounds are primarily located in the skins and seeds of grape berries, it is implicit that winemaking practices, which influence the extraction of these compounds from the skins and seeds into the wine, would influence their concentration in the final wine.

**Table 4.** Summary of resveratrol's effects in healthy humans.

Area	N.of studies (Ref. to Table 1)	Daily dose range (Lowest active dose)	Comments
Cardiovascular	4 (26–29)	0.030–2 g (0.030 for endothelial function)	Decreased levels of risk factors for CVD: ApoB48 and ApoB100, endothelial function and oxidative stress, etc.
Insulin sensitivity	5 (30–34)	0.075–1 g	No significant result on glycemia and insulin sensitivity.
Chemioprevention	3 (35–37)	0.005–5 g	No significant effect.
Training performance	4 (38–41)	0.15–2 g	No effects on training performance.
Cognitive function	1 (42)	0.250–0.5 (0.25)	No effect on cognitive function, improvement in cerebral blood flow.
Hepatic metabolic function	1 (43)	1 g	Possible effect (positive or negative) on hepatic metabolism of drug.
Bone mineralization	1 (44)	0.15–0.5 g	Dose-response improvement of bone density.
Immunomodulation	1 (45)	5 g	Improvement of immunomodulation and inflammation.

The influence of winemaking techniques in conjunction with grape variety on the resveratrol concentration in wines has also been studied for the cultivars Merlot, Cabernet Sauvignon and Prokupac as well as for Pinot Noir (Atanacković et al. 2012). Applied winemaking technologies included thermovinification and the separation of must from pomace. The total resveratrol concentration in analysed wine samples ranged from 0.35 to 4.85 mg/L. Merlot wines had the highest average resveratrol concentration, while the lowest was found for the native cultivar Prokupac.

Although resveratrol concentrations in the red wines depended on the grape variety, correlation between the applied winemaking technology and the concentration of resveratrol in wines was not observed. Data suggest, however, that the most important factor in winemaking is the maceration time, since the highest concentrations of resveratrol and piceid, and the highest antioxidant activity were found following six and ten days of maceration for Vranec and Merlot wines (Kostadinović et al. 2012). In addition, the techniques of skin extraction and enzymatic hydrolysis of glucoside forms play an important role in resultant resveratrol concentration of wine, because stilbenes are mainly found in skin cells of the berry (Bavaresco et al. 2012).

To enhance resveratrol concentrations in wine pre and post fermentation, must could be enriched with resveratrol-rich grape skins.

Alternatively, grape-derived resveratrol could simply be added during winemaking; however, this practice is not allowed in all countries. Sulfur dioxide is added during winemaking to inhibit the growth of unwanted yeasts and bacteria, and to protect wine from oxidation. Sulfur dioxide is, however, associated with allergies and sensitivities in susceptible individuals, which is reflected in mandated warning labelling for added amounts greater than 10 mg/L (Stockley and Johnson 2015). Consequently, alternatives to sulfur dioxide are being sought. A pilot study assessed the replacement of sulfur dioxide with the antioxidant resveratrol during winemaking (Pastor et al. 2015). Two different amounts of resveratrol (150 mg/L and 300 mg/L), along with reduced or no sulfur dioxide added during winemaking (Pastor et al. 2015), had similar effects on the organoleptic or sensory properties of the resultant wine. The beneficial effects of adding resveratrol to reduce or replace sulfur dioxide is two-fold for consumers — a reduced risk of an adverse reaction with a potentially reduced risk of mortality.

## Conclusions

The oxidative stress is an imbalance between antioxidant molecule production and the oxygen reactive species, which are a natural consequence of cellular breathing that produces energy and is performed in mitochondria. This homeostasis is a delicate balance in molecular biology aimed to maintain the suitable redox potential. If the redox potential increases, it means that we are facing an increased production of oxygen free radicals, which is one of the first risk factors of non-transmissible chronic diseases, aging and its consequences like cardiovascular, metabolic and neurodegenerative diseases and cancer. Given that the world's population is growing at an unprecedented rate, where percentage of people worldwide aged 65 and

over is projected to double to approximately 17 percent of the world's population by 2050 (He et al. 2016), research into simple dietary interventions to reduce the risk of these chronic diseases have become increasingly important. Resveratrol has been consistently shown to be a biologically active compound since 1992, having potential effects on human health and diseases. Wine is the main sources of dietary resveratrol although average intake is in the order of few mg/day and it is not enough to support healthy biological actions. Therefore, we need to thoroughly investigate resveratrol's effects in humans and explore means to increase its concentration to be biologically relevant in foods (mainly fruits and derivatives) and beverages (such as juices and wine).

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