Multiple sclerosis (MS), a severely debilitating disorder, is identified by progressive demyelination and axonal damage in the central nervous system (CNS). Although the underlying causes of the disease are unknown, it is accepted in general that MS starts when autoreactive T-cells penetrate the CNS to attack the nervous system (1). Several types of MS have been recognized, the most common of which is characterized by waxing and waning of signs and symptoms to produce a “relapsing-remitting” clinical presentation. “Relapsing-remitting MS” affects 85% of MS patients (2). About 30% of these patients experience “secondary progressive MS” within a decade (3), a type with less inflammation and more neurodegeneration. “Primary progressive MS” is a distinct type of MS which is not obviously correlated with relapses and shows neurodegeneration without inflammatory change. The late-stage sequelae from advanced MS include permanent disability and death (4). Although the etiology of this autoimmune disorder is intricate, it has been suggested that both genetic susceptibility and non-genetic triggers have a role (5).

Medicines used in MS are not completely functional and various side effects are reported by patients. Nowadays, complementary and alternative medicines (CAMs) are used increasingly and patients tend to use this kind of treatment. Having a healthy lifestyle and using CAM treatment can eliminate some of the symptoms and improve the quality of life in these patients. Many patients use CAM therapies to decrease their symptoms (6). This study attempted to investigate the use of herbal remedies and supplements to treat MS to confirm or rule out the effectiveness or ineffectiveness of these supplementary medicines.

### Herbal and Supplement Products for the Treatment of Multiple Sclerosis

Using herbal products and supplements in patients with MS is a new area for the research (7). Herbal bioactive compounds like flavonoids, lipoic acid, vitamin C, and so on are the most efficient therapies in relapsing and progressive forms of MS because of the neuroprotective and anti-inflammatory properties (8). Moreover, it should be noted that polyphenols, terpenes, alkaloids, anthocyanidin glycosides, plant amines, volatile oils, and so on play a noticeable role in the treatment of MS (9). Several studies investigated the role of minerals, vitamins, and other related supplements in symptomatic and
disease-modifying treatments in MS patients (10). However, inadequate findings are available to make recommendations regarding their effectiveness and safety for all patients (11). The commonly used vitamin and mineral supplements with antioxidant effects include vitamin D, C, and E and selenium (12).

Various herbal medicines have been studied in the treatment of MS, which are reported as follow:

**Borage seed oil (Borago officinalis)**

Borage seed oil has a gamma linoleic acid content of 25% which can be regarded as a TNF-α suppressor. In addition, borage seed oil can elevate prostaglandin E (PGE) levels, which leads to an increase in cyclic adenosine monophosphate (cAMP). The point is that cAMP augmentation clarifies anti-inflammatory effects in MS treatment (13).

**Blackcurrant (Ribes nigrum)**

The reduction of proinflammatory mediators including tumor necrosis factor-alpha (TNF-α) and Interleukin-1β (IL-1β) in peripheral blood monocytes and anti-inflammatory effects are induced by Blackcurrant seed oil in MS (14).

**Bilberry (Vaccinium myrtillus)**

The mechanism of bilberry in inflammatory diseases such as MS is through decreasing high-sensitivity C-reactive protein (hs-CRP), IL-12, IL-6, and Lipopolysaccharide concentrations. The anti-inflammatory effect of bilberry extract is exerted by anthocyanins. In addition, anthocyanins can improve visual impairment in MS patients (15).

**Cannabis (Cannabis sativa L)**

Several reports on the usefulness of cannabis in treating MS have been published. Consumption of cannabis can lead to various effects, including treatment of spasticity, improvement of tremor, reduction of depression, relief of pain, and recovery of anxiety. Both lipophilic nature and central depressant effects of cannabinoids lead to thoughts that their mechanism of action occurs via membrane disruption, similar to general anesthetics. The first cannabinoid receptor (CB1), a G-protein coupled receptor, inhibits adenylate cyclase and regulates Ca2+ and K+ channels. The receptor may also interact with other pathways, such as inositol phospholipid pathway. CNS (particularly basal ganglia, hippocampus, and cerebellum) is the main area for CB1 receptors. The inhibition of neurotransmitter release is the overall effect of CB1 receptor activation in the CNS (7).

**Cat’s Claw (Uncaria tomentosa)**

The anti-inflammatory effect of the bark of this plant is the same as dexamethasone. Furthermore, this plant can reduce IL-4 level, while dexamethasone does not have this property. It should be noted that Cat’s Claw extract can decrease PGE-2 production (16).

**Devil’s Claw (Harpagophytum procumbens)**

The root extract of Devil’s Claw inhibits inflammatory cytokine (IL-6, IL-1β, and TNF-α, and PGE-2), prevents arachidonic acid metabolism, and induces eicosanoid biosynthesis, leading to COX-2 inhibition and inflammation reduction (17).

**Dog Rose (Rosa canina)**

The anti-inflammatory action of the rosehip seeds is induced by inhibition of PGE-1 which leads to the down-regulatory effect on COX-1, COX-2, and leukotriene B4 (LTB 4) (18).

**Evening Primrose oil (Oenothera biennis)**

This oil contains sterols such as ß-sitosterol and campesterol, which have an effect on the modulators such as nitric oxide (NO), IL-1β, TNF-α, and thromboxane B2 (TXB2), leading to the suppression of the COX-2 genome, and anti-inflammatory outcome (19).

**Ginger (Zingiber officinalis)**

In several investigations, it has been indicated that Ginger has immunomodulatory, anti-inflammatory, and anti-oxidative characteristics. Inflammation can be decreased in MS patients by Ginger via reducing the production of TNF-α and hs-CRP. Moreover, the inhibition of cyclooxygenase and lipoxygenase pathways in synovial fluid is a mechanism that leads to analgesic effects (20).

**Indian Frankincense (Boswellia serrata)**

The mechanism of Indian Frankincense is through the reduction of erythrocyte sedimentation rate and plasma levels of leukotriene C4, NO, and malondialdehyde. In addition, the reduction of inflammatory cytokines such as TNF-α, IL-1β, IL-6, IFN-γ, and PGE2 can be mentioned (21, 22).

**Olive oil (Olea europaea)**

Olive oil exerts its effect through modulation and decrease of pro-inflammatory cytokines, TXB2, and leukotriene B4, leading to the reduction of inflammation in MS patients. Moreover, the reduction of lipid and protein oxidation and elevation of glutathione peroxidase can protect against oxidative damage (23).

**Rosemary (Rosmarinus officinalis)**

The level of inflammatory mediators such as TNF-α and IL-1β can be reduced by rosemary extract (24). Additionally, according to an open-label trial, the use of rosemary extract reduced hs-CRP (an indicator of the presence of inflammation), indicating that rosemary is involved in reducing inflammation (25).
**ussian olive or Oleaster** *(Elaeagnus angustifolia)*

In a randomized clinical trial, a significant decrease in TNF-α and IL-10 level was observed after using Oleaster. The anti-inflammatory properties of this fruit extract can be explained by inhibition of COX-1 and COX-2 (26).

**Saffron**

The therapeutic effects of saffron components, like safranal, crocin, and crocetin seem to include anticarcinogenic, antioxidant, and immunomodulating properties (27).

**Sage** *(Salvia officinalis)*

Carnosol and carnosic acid are two important components in chloroform extract of *Salvia* leaves. It has been shown that these phenolic diterpenes have anti-inflammatory effects (28) and can inhibit the production of PGE through the inhibition of microsomal PGE 2 synthase-1 (29, 30).

**The Stinging Nettle** *(Urtica dioica)*

The activation of NF-κB (31) and reduction of PGD2 production can explain the anti-inflammatory effects of *Urtica Dioica* leaves extract. Moreover, Stinging Nettle used simultaneously with nonsteroidal anti-inflammatory drugs induces an excellent synergistic effect, with a remarkable reduction in CRP level (32).

**Turmeric** *(Curcuma longa)*

Curcumin can inhibit inflammatory proteins and cytokines. The inhibition of the differentiation of Th17 cells is noticed in a study on chronic inflammatory diseases. The importance of Th17 cells in CNS infection in patients with MS and experimental autoimmune Myasthenia gravis has been demonstrated (33).

Figure 1 summarizes the effects of some of the medicinal plants in the treatment of MS.

**List of the Vitamins and Supplements Used for the Treatment of Multiple Sclerosis**

**Vitamin B12:** This vitamin is known as cobalamin and has important structural and functional roles in the CNS, and its deficiency leads to anemia, axonal degeneration, and death (34). Based on this information, fixing the deficiency of this vitamin can be effective in improving the quality of life in MS patients (33). The nature of this disease that is associated with megaloblastic and pernicious anemia along with reduced serum levels of vitamin B12 in patients with MS treated with interferon and Copaxone® is considered in numerous studies. Moreover, the role of this vitamin in myelin repair should be noticed (34).

**Vitamin D:** Vitamin D can suppress the function of antigen-presenting cells which leads to a reduction in the penetration of inflammation in the CNS. The mechanism that seems to affect vitamin D nutrition in MS involves the paracrine or autocrine action of 25-hydroxyvitamin D by enzyme 1α-hydroxylase in peripheral tissues which play a role in the function of the immune and nervous system. Optimum serum concentrations of 25-hydroxyvitamin D throughout the year may be beneficial for patients with MS, both for the removal of immune cells from disease activity as well as the reduction of disease-related complications, including increased bone turnover, fracture and muscle weakness (35).

**Vitamins E and C:** It has been observed that antioxidant deficiency can increase the risk of developing MS in MS patients. Indeed, antioxidants such as vitamin E (alpha-tocopherol) and vitamin C (ascorbic acid) in the MS animal models reduced the clinical symptoms of the disease. Antioxidants have the ability to reduce the symptoms of the disease by targeting specific pathogens and supporting recovery in MS (36). It should be noted that cell damage can be reduced by reducing harmful free radicals. The immune system in the nervous system can be attacked and damaged by free radicals (37).

**Zinc:** Numerous functions in the immune system including peripheral T-cell count, cytotoxic T-cell activity, T-helper cell function, NK-cell activity, and macrophage and neutrophil functions are influenced by zinc (Zn) deficiency (38). Zn is predominantly found in presynaptic vesicles in neurons. It is clear that effective Zn homeostasis in the brain is important (39). Increasing Zn can lead to the expression of the high-affinity receptors for IL-2, which are important for the proliferation and differentiation of CD4+ and CD8+ lymphocytes to effector cells (40).

**CoQ10:** CoQ10 has different mechanisms for anti-inflammatory activity in MS. Among these mechanisms, the immunomodulatory properties of CoQ10 are more prominent. CoAQ10 can reduce the production of certain inflammatory mediators such as IL-6. Moreover, it can elevate antioxidant enzyme activity and diminish oxidative stress in patients with relapsing-remitting MS (41).

**Polyunsaturated fatty acids:** A specific deficiency of linoleic acid in the serum of MS patients has been detected by biochemical studies (42).

**Omega 3, 6:** The findings of a study indicated that Omega 3 and 6 have anti-inflammatory effects by reducing T-cell proliferation (43).

**L-Carnitine:** L-Carnitine is a natural metabolic drug that acts as a carrier molecule for long-chain fatty acids in mitochondria and generates energy. L-carnitine deficiency is associated with the accumulation of acyl CoA esters and disorders of intermediary metabolism (44). L-carnitine is reported to be effective in reducing fatigue in MS patients. It is one of the amino acid derivatives that plays an important role in the metabolism of lipids and is a key factor in mitochondrial energy production (45); therefore, it can improve fatigue in MS patients (46). Table 1 represents the effects of some supplements and medicinal plants in MS treatment.

**Conclusion**

Supplement therapy is regarded as a way to improve the symptoms of the disease with fewer complications for
Table 1. Summary of the Studies Conducted to Determine the Effects of Some of the Supplements and Medicinal Plants in MS Treatment

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Result</th>
<th>Publication Year</th>
<th>Number of Subjects</th>
<th>Amount</th>
<th>Duration</th>
<th>Subjects</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin A</td>
<td>Results of this study suggest that using this vitamin could have a regulatory role in the treatment of autoimmune diseases such as MS. Results of this study suggest that anemia improves with vitamin B12 and folic acid supplementation which reveals the potential role of these two vitamins in improving the quality of life of MS patients. Additionally, serum homocysteine level decreases.</td>
<td>2013</td>
<td>35</td>
<td>25000 IU/day</td>
<td>1 year</td>
<td>Human</td>
<td>(47)</td>
</tr>
<tr>
<td>Vitamin B12</td>
<td>Results of this study indicate that 1,25-(OH)2D3 halted EAE (Experimental autoimmune encephalomyelitis) progression and maintained the EAE disease severity below stage 2 for the duration of the observations (40 days post immunization).</td>
<td>1996</td>
<td>Three groups of twelve</td>
<td>20 ng/day</td>
<td>5-8 weeks</td>
<td>Mice</td>
<td>(49)</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Results of this study indicate that use of vitamin D supplements could have a substantial impact on bone density, fracture risk, morbidity, and mortality in MS patients. Results of this study indicate that supplemental with a high dose of vitamin D3 cannot reduce relapse rate.</td>
<td>1994</td>
<td>80</td>
<td>Vitamin D (800 IU) and Calcium (1200 mg)</td>
<td>23 months</td>
<td>Human</td>
<td>(50)</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Results of this study indicate that supplemental with a high dose of vitamin D3 cannot reduce relapse rate.</td>
<td>2012</td>
<td>35</td>
<td>20000 IU/day</td>
<td>96 weeks</td>
<td>Human</td>
<td>(51)</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Lower 25(OH)D levels have been reported in MS patients compared to healthy control populations.</td>
<td>2008</td>
<td>267</td>
<td>-</td>
<td>&lt;5 Years</td>
<td>Human</td>
<td>(52)</td>
</tr>
</tbody>
</table>

Figure 1. Effects of Some of the Medicinal Plants in the Treatment of Multiple Sclerosis
<table>
<thead>
<tr>
<th>Supplement</th>
<th>Results</th>
<th>Year</th>
<th>Dose</th>
<th>Duration</th>
<th>Study Type</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin D</td>
<td>Results of this study indicate that higher level of sun exposure rather than 25(OH)D levels were associated with less depressive symptoms and levels of fatigue in MS patients.</td>
<td>2012</td>
<td>80</td>
<td>high-dose (average daily dose 10200 IU) or low-dose (average daily dose 200 IU)</td>
<td>18 months</td>
<td>Human (53)</td>
</tr>
<tr>
<td>Vitamin D+Ca</td>
<td>Results of this study indicate that MS patients treated with Ca+D have fewer relapse events and a persistent reduction in T-cell proliferation compared to controls.</td>
<td>2010</td>
<td>49</td>
<td>Vitamin D 10000 IU/day, Ca 1200 mg/d</td>
<td>52 weeks</td>
<td>Human (54)</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Results of this study support a protective effect of vitamin D intake on the risk of developing MS.</td>
<td>2004</td>
<td>173</td>
<td>400 IU/day</td>
<td>2 year</td>
<td>Human (55)</td>
</tr>
<tr>
<td>Vitamins E and C</td>
<td>Results of this study indicate that the increase of levels of vitamin C and E can be helpful as antioxidants in the recovery of MS.</td>
<td>2005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(36)</td>
</tr>
<tr>
<td>Zinc and Copper</td>
<td>Results of this study indicate that lower level of Zn and higher level of Cu in serum were found in the MS patients compared to the control.</td>
<td>2012</td>
<td>60</td>
<td>-</td>
<td>9 months</td>
<td>Human (56)</td>
</tr>
<tr>
<td>CoQ10</td>
<td>Results of this study indicate that CoQ10 can decrease oxidative stress and increase antioxidant enzyme activity in patients with relapsing-remitting MS.</td>
<td>2014</td>
<td>60</td>
<td>200 mg/d</td>
<td>24 weeks</td>
<td>Human (41)</td>
</tr>
<tr>
<td>Linoleate</td>
<td>Results of this study indicate that relapse of MS was decreased after 9-12 months.</td>
<td>1973</td>
<td>87</td>
<td>30 mL of a sunflower seed oil emulsion providing 6-8 g of linoleic acid</td>
<td>2 years</td>
<td>Human (57)</td>
</tr>
<tr>
<td>Linoleic acid</td>
<td>Results of this study indicate that linoleic acid marginally affected the duration and severity of relapses of MS but had no effect on the overall disability.</td>
<td>1978</td>
<td>116</td>
<td>20 g linoleic acid daily</td>
<td>12-24 months</td>
<td>Human (42)</td>
</tr>
<tr>
<td>Omega-3</td>
<td>Results of this study indicate that omega-3 fatty acid can be used as an augmentation therapy for treatment-resistant depression in MS patients.</td>
<td>2016</td>
<td>39</td>
<td>6 g daily</td>
<td>3 months</td>
<td>Human (58)</td>
</tr>
<tr>
<td>Omega-3</td>
<td>Results of this study indicate that omega-3 fatty acid has the ability to significantly decrease matrix metalloproteinase-9 levels and was well tolerated at a dose of 9.6 g/d over 3 months so can be effective in the process of MS improvement.</td>
<td>2009</td>
<td>31</td>
<td>9.6 g daily fish oil</td>
<td>6 months</td>
<td>Human (59)</td>
</tr>
<tr>
<td>Omega-3 and Omega-6</td>
<td>Results of this study indicate that treatment with PLP10 significantly reduced annualized relapse rate and the risk of sustained disability progression without any serious adverse events.</td>
<td>2018</td>
<td>41</td>
<td>Omega-3 600 mg/d, omega-6 650 mg/d</td>
<td>30 months</td>
<td>Human (43)</td>
</tr>
<tr>
<td>Acetyl L-carnitine</td>
<td>Results of this study indicate that acetyl L-carnitine is well tolerated by patients with MS and is more effective than amantadine in the treatment of MS-related fatigue.</td>
<td>2004</td>
<td>60</td>
<td>100 mg twice daily</td>
<td>3 months</td>
<td>Human (60)</td>
</tr>
<tr>
<td><strong>Cannabis-based medicinal extracts</strong></td>
<td>This study suggests that patients with MS who derive symptom relief from cannabis-based medicinal extract in the first 10 weeks generally maintain that symptom relief over an extended period of treatment without any increase in dose.</td>
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<tr>
<td><strong>Cannabis-based medicinal extracts</strong></td>
<td>The results of this study suggest that Sativex® is an effective treatment for spasticity associated with MS. The results of this study indicate that overall effect of curcumin on neuroglial cells involves reduction of astrocytes proliferation, elevation of myelogenesis and elevation of activity and differentiation of oligodendrocytes.</td>
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<tr>
<td><strong>Curcumin</strong></td>
<td>The results of this study indicate that EPO consumption increases cognitive function, vitality, and life satisfaction and decreases pain and fatigue. The results of this study indicate that 6-shogaol or 6-paradol can have therapeutic efficacy for experimental autoimmune encephalomyelitis by reducing neuroinflammatory responses. Moreover, these two active ingredients of ginger have therapeutic potential for MS.</td>
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<tr>
<td><strong>Evening Primrose Oil (EPO)</strong></td>
<td>The results of this study indicate that EPO consumption increases cognitive function, vitality, and life satisfaction and decreases pain and fatigue. The results of this study indicate that 6-shogaol or 6-paradol can have therapeutic efficacy for experimental autoimmune encephalomyelitis by reducing neuroinflammatory responses. Moreover, these two active ingredients of ginger have therapeutic potential for MS.</td>
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<tr>
<td><strong>Ginger</strong></td>
<td>Results of this study indicate that 3-month ginseng treatment can reduce fatigue and has a significant positive effect on quality of life. Results of this study indicate that American ginseng extract at a dose in common use was well tolerated but was no better than placebo in improving fatigue using validated fatigue outcome measures, the Fatigue Severity Scale (FSS) and Modified Fatigue Impact Scale (MFIS).</td>
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<tr>
<td><strong>Ginseng</strong></td>
<td>Results of this study indicate that Bee venom has immune suppressive and anti-inflammatory effects in MS disease. The results of this study indicate that the utilization of fish oil and olive oil increases the fluidity of the mitochondrial membranes and decreases the catabolic activity of ATP synthase in platelets of patients with relapsing-remitting multiple sclerosis.</td>
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<tr>
<td><strong>Honey bee venom</strong></td>
<td>Results of this study indicate that use of 100 mg saffron has temporary immunomodulatory activities without any adverse effects.</td>
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<tr>
<td><strong>Olive oil</strong></td>
<td>Results of this study indicate that saffron has anti-inflammatory effects.</td>
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<tr>
<td><strong>Saffron</strong></td>
<td>Results of this study indicate that saffron has anti-inflammatory effects.</td>
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<tr>
<td><strong>Saffron</strong></td>
<td>Results of this study indicate that saffron has anti-inflammatory effects.</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Dose</th>
<th>Formulation</th>
<th>Duration</th>
<th>Study Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>11 sprays daily (equivalent to 30 mg THC and 28 mg CBD)</td>
<td>Human</td>
<td>10 weeks</td>
<td>Human</td>
</tr>
<tr>
<td>2004</td>
<td>2.5-120 mg daily, in divided doses</td>
<td>Human</td>
<td>70 days</td>
<td>Human</td>
</tr>
<tr>
<td>2010</td>
<td>4, 6, and 8 g daily</td>
<td>Rat</td>
<td>3 months</td>
<td>Rat</td>
</tr>
<tr>
<td>2018</td>
<td>1 g oral capsule containing EPO every 12 hours</td>
<td>Human</td>
<td>3 months</td>
<td>Human</td>
</tr>
<tr>
<td>2018</td>
<td>6-shogaol (5 mg/kg), or 6-paradol (5 mg/kg) orally daily</td>
<td>Mice</td>
<td>13 days</td>
<td>Mice</td>
</tr>
<tr>
<td>2013</td>
<td>250 mg ginseng</td>
<td>Human</td>
<td>3 months</td>
<td>Human</td>
</tr>
<tr>
<td>2011</td>
<td>100 mg, 200 mg, 400 mg/d</td>
<td>Human</td>
<td>6 weeks</td>
<td>Human</td>
</tr>
<tr>
<td>2012</td>
<td>2 mg/kg</td>
<td>Rat</td>
<td>20 day</td>
<td>Rat</td>
</tr>
<tr>
<td>2017</td>
<td>1 g oleic acid daily</td>
<td>Human</td>
<td>9 months</td>
<td>Human</td>
</tr>
<tr>
<td>2011</td>
<td>100 mg daily</td>
<td>Human</td>
<td>6 weeks</td>
<td>Human</td>
</tr>
<tr>
<td>2012</td>
<td>25 to 100 mg/kg/d</td>
<td>Mice</td>
<td>3 years</td>
<td>Mice</td>
</tr>
</tbody>
</table>
patients, but health care professionals face problems in finding information regarding the usefulness of supplements. The point is that there are few scientific resources to introduce the effectiveness, mechanism, and usage of natural substances for treating the disease. In addition, receiving conventional therapies induces many side effects in MS patients. Discussing the available supplement with their usage may lead to an increasing trend in the use of CAMs in MS because of fewer side effects, more comfort, and more preventive effects.

**Conflict of Interests**
The authors declare that they have no conflict of interests.

**Acknowledgment**
The authors would like to thank Mr. Tavakoli for his contribution in preparing the figures.

**Funding**
There is no financial support.

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