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Therapeutic Fasting and Intermittent Fasting

Therapeutic fasting and **intermittent fasting** are therapeutic approaches that induce metabolic and cellular adaptations through targeted food abstinence. The human evidence base is extensive. The most notable finding: a significant proportion of controlled studies examine **metabolic parameters**, yet the applicability to chronic diseases remains limited.

1,964

STUDIES IN
TOTAL

1,257

IN HUMANS

577

OF WHICH
CONTROLLED

30

IN ANIMALS

15

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-04

How to Read This Dossier

ESTABLISHED

measured in humans, with a comparison group

PLAUSIBLE

supported by mechanism, animal studies or observation

HYPOTHESIS

a likely connection that still needs to be tested

Therapeutic Fasting and Intermittent Fasting at a Glance

ORIGIN:

Therapeutic fasting and intermittent fasting are targeted nutritional abstinence procedures that induce metabolic and cellular adaptations such as autophagy, reduction of insulin resistance, and metabolic flexibility. Therapeutic fasting involves multi-day to multi-week phases of complete or significantly reduced food intake, often under medical supervision, while intermittent fasting incorporates time-restricted eating windows (e.g., 16:8 or 5:2) or periodic fasting days into daily life. Both approaches stem from traditional and modern nutritional medicine strategies for metabolic regulation, anti-inflammatory effects, or detoxification.

EVIDENCE BASE:

299 evaluated studies · 119 controlled human trials · 67 observational studies · 26 review articles · 2 animal studies · 0 cell culture studies

STRONGEST EVIDENCE:

- **Metabolism** Randomised controlled trials showed effects of 16:8 intermittent fasting on weight loss, HbA_{1c} reduction (~1.54%), and insulin resistance (HOMA-IR) in individuals with overweight and type 2 diabetes. Comparable effects to daily caloric restriction were observed in patients with NAFLD (IHTG reduction).
- **Cardiovascular Markers** Early intermittent fasting (8-hour eating window) combined with caloric restriction showed improvements in systolic blood pressure (~10 mmHg) and insulin resistance in patients with obesity, though without blinding or assessment of psychological parameters.
- **Safety and Tolerability** Controlled studies showed safety of intermittent fasting in healthy adults, individuals with overweight, and those with type 2 diabetes. Risks such as muscle loss or malnutrition have not been systematically investigated in short-term studies, particularly in at-risk groups.
- **Inflammatory Processes** Intermittent fasting reduced pro-inflammatory cytokines (IL-6: ~1.2 pg/ml) in small study populations. A combination with a low-sugar diet showed anti-inflammatory effects in NAFLD, though long-term data are lacking.

LIMITATIONS:

- **Oncology** Preclinical studies in animal models indicate potential anti-tumour effects and enhanced chemotherapy efficacy. These findings have not been investigated in humans, and risks such as malnutrition or sarcopenia remain insufficiently explored in clinical settings.
- **Cognition and Mental Health** The evidence base is still developing and inconsistent. Effects on attention or memory are based on small samples without standardised measurements.
- **Long-Term Data** Studies exceeding 12 months are lacking regarding the sustainability of effects, risks such as muscle loss or malnutrition, and comparisons with established therapies (e.g., pharmacological diabetes treatment).

CLASSIFICATION:

Therapeutic fasting and intermittent fasting are evidence-based approaches for metabolic regulation, with demonstrated effects on weight loss, insulin resistance, and cardiovascular markers. However, their potential in chronic conditions such as cancer or neurodegenerative disorders remains inadequately explored.

1. What Therapeutic Fasting and Intermittent Fasting Are

Therapeutic fasting refers to a multi-day to multi-week phase of complete or significantly reduced food intake, often under medical supervision. It is traditionally used for detoxification, anti-inflammatory effects, or metabolic regulation. **Intermittent fasting** involves time-restricted eating windows (e.g., 16:8 or 5:2) or periodic fasting days integrated into daily life. Both approaches aim to induce **autophagy**, **reduction of insulin resistance**, and **metabolic flexibility**, though they differ in duration, intensity, and objectives.

Critical to the evidence base is the **diversity of fasting protocols**: therapeutic fasting is typically conducted in inpatient settings or under supervision, while intermittent fasting varies in outpatient settings (e.g., early vs. late eating windows, daily vs. weekly cycles). **Compliance measurement** is performed via food diaries, biomarkers (e.g., ketone bodies), or digital tools, though **standardisation** remains a challenge. Additionally, **target populations** differ widely—from healthy individuals to those with obesity, metabolic syndrome, or oncological conditions.

2. What the Studies Show in Detail

The foundational human studies and key reviews—by application, population, duration, preparation, measured outcomes, and results—as reported in the original publications. Figures are included only where the study provides them.

Distribution of **controlled human studies** by application—numbers are not additive, as a single study may be assigned to multiple categories:

APPLICATION	CONTROLLED STUDIES
Metabolism	90
Safety and Tolerability	36
Fatigue and Stress	31
Heart and Circulation	27
Inflammatory Processes	20

APPLICATION	CONTROLLED STUDIES
Oncology	14
Gut and Microbiome	10
Cognition and Mental Health	9

Metabolism

The primary endpoint was weight loss. Secondary endpoints included changes in fat mass, fat-free mass, fasting insulin, fasting blood glucose, HbA_{1c}, estimated energy intake, total energy expenditure, and resting energy expenditure. Limitations included the lack of blinding, and compliance was primarily assessed via self-reporting. The results suggest that 16:8 intermittent fasting may lead to clinically relevant weight reduction in individuals with overweight or obesity, though long-term data on sustainability are lacking.

A further randomised controlled trial ⁽³⁾ examined 120 adults with overweight and type 2 diabetes (T2D) assigned to either a 10-hour intermittent fasting group (ad libitum food intake between 08:00 and 18:00, fasting from 18:00 to 08:00) or a control group. After 12 weeks, the intervention group showed significant improvements: HbA_{1c} decreased by -1.54% (± 0.19) compared to the control group ($p < 0.001$), body weight reduced by -2.98 kg (± 0.43 , $p < 0.001$), and insulin resistance (HOMA-IR) improved by -0.51 (± 0.08 , $p = 0.02$). Additionally, triglycerides decreased (-0.23 mmol/L, $p = 0.006$) and the medication effect score dropped (-0.66, $p = 0.006$). The study was not blinded, and participants were predominantly of Asian descent, limiting generalisability. Nonetheless, it highlights the potential of intermittent fasting to improve glycaemic control in T2D patients.

In a 12-month randomised study ⁽⁴⁾ involving 88 adults with obesity and non-alcoholic fatty liver disease (NAFLD), time-restricted eating (TRE, food intake between 08:00 and 16:00) was compared with daily caloric restriction (DCR, 1500–1800 kcal/day for men, 1200–1500 kcal/day for women). The primary endpoint was the change in intrahepatic triglyceride content (IHTG), measured by MRI. The study showed that TRE achieves comparable metabolic effects to DCR in patients with NAFLD; however, data on long-term effects on liver fibrosis or inflammatory markers are lacking.

A randomised study involving 209 adults at elevated risk of type 2 diabetes (T2D) ⁽⁵⁾ compared intermittent fasting plus early time-restricted eating (iTRE: 30% of energy requirements consumed between 08:00 and 12:00, followed by a 20-hour fast on three non-consecutive days per week) with daily caloric restriction (CR: 70% of energy requirements) and standard care. After 6 months, iTRE improved glucose tolerance more than CR (-10.10 mg/dl·min vs. -3.57 mg/dl·min, $p = 0.03$), though these differences were no longer detectable at 18 months. The study suggests that combining fasting with an early eating window may offer short-term metabolic benefits, but long-term effects remain unclear. A limitation was the open-label design, and compliance was not objectively measured. **Assumption:** The combination of time restriction and caloric reduction may have synergistic effects that go beyond mere caloric restriction, though studies with longer follow-up and standardised dietary protocols are lacking.

Cognition and Mental Health

In a 14-week randomised study ⁽²⁾ involving 90 adults (aged 25–75, BMI 39.6 ± 6.7) with obesity, early time-restricted eating (eTRE: 8-hour eating window from 07:00 to 15:00) was compared with a control group (≥ 12 -hour eating window), with both groups following a calorie-reduced diet (ER). Primary endpoints were weight and fat loss. Additionally, the eTRE group showed improvements in systolic blood pressure (-10 mmHg vs. -3 mmHg, $p = 0.04$) and insulin resistance (HOMA-IR: -1.4 vs. [...]). The study was not blinded, and psychological parameters such as mood or cognitive performance were not assessed. Nonetheless, it suggests that early time-restricted eating may offer metabolic and cardiovascular benefits beyond caloric restriction alone.

Assumption: The timing of food intake in synchrony with the circadian rhythm may play a role, though studies explicitly examining cognitive or psychological effects are lacking.

Oncology

A review article analysed preclinical and clinical data on intermittent fasting (IF) in cancer prevention and therapy. Animal studies indicate that IF may inhibit tumour growth and enhance the efficacy of chemotherapy, though results vary by cancer type and stage. These findings are preclinical, and the effects in humans remain unconfirmed. In a small clinical study involving breast cancer patients, a 48-hour fast before and after chemotherapy reduced haematotoxicity and improved quality of life. However, the authors emphasise that IF should not be recommended during active cancer therapy outside clinical trials due to risks such as malnutrition or sarcopenia. **Assumption:** IF may be a viable adjuvant therapy in certain cancers, though large randomised studies investigating safety and efficacy across different cancer types and treatment phases are lacking.

A further review article discusses nutrition-based interventions in oncology and highlights that fasting-mimicking diets (FMD) may enhance the efficacy of immunotherapies in preclinical models. These findings have not yet been confirmed in humans, and the translatability of these results remains unclear. The authors stress the need for standardised studies that account for both macro- and micronutrient composition during fasting phases. **Assumption:** The combination of fasting and specific nutrients may have synergistic effects, though the underlying mechanisms and optimal protocols are not yet sufficiently explored.

Inflammatory Processes

The IF-P group exhibited a significant reduction in pro-inflammatory cytokines (e.g., IL-6: -1.2 pg/ml, $p < 0.05$) and an increase in microbes of the *Christensenellaceae* family, associated with metabolic health. Additionally, gastrointestinal symptoms improved ($p < 0.05$). The study was not blinded, and the sample size was small. Nonetheless, it provides preliminary evidence that IF-P may influence inflammatory markers and the gut microbiome in a preclinical setting. **Assumption:** Modulation of the gut microbiome may be a central mechanism, though studies examining clinical anti-inflammatory effects in humans are lacking.

A 12-week randomised study ⁽⁶⁾ involving 70 patients with NAFLD compared intermittent fasting (16:8, combined with a low-sugar diet) with a control group. The study was not blinded, and compliance was not objectively measured. It suggests that the combination may influence inflammatory markers in NAFLD, though the contribution of intermittent fasting alone remains unclear. **Assumption:** The combination of time restriction and dietary quality may act

synergistically, though data on long-term effects on liver fibrosis or cardiovascular endpoints are lacking.

Overall Picture

The available studies demonstrate that intermittent fasting and therapeutic fasting consistently lead to weight loss and improvements in insulin resistance and metabolic parameters across various populations (overweight, obesity, type 2 diabetes, NAFLD). The data are particularly robust for 16:8 intermittent fasting, which showed significant effects on body weight, fat mass, and HbA_{1c} in multiple randomised studies (¹, ³, ⁴). However, the effects are often modest and not always superior to continuous caloric restriction. Furthermore, long-term data (>12 months) on the sustainability of these effects and potential risks such as muscle loss or malnutrition are lacking. **Assumption:** The combination of time restriction and caloric reduction may have synergistic effects, though optimal protocols (e.g., eating window, fasting duration) are not yet sufficiently defined.

In oncology and inflammatory diseases, the data on fasting interventions are considerably sparser. While preclinical studies demonstrate effects on tumour growth and inflammatory markers in animal models, these findings have not yet been confirmed in humans. Large clinical trials confirming safety and efficacy in these populations are lacking. A particularly critical issue is the risk of malnutrition in cancer patients, which has not been systematically investigated in any of the available studies. **Hypothesis:** Fasting may be beneficial in certain contexts (e.g., as adjuvant therapy), but the underlying mechanisms and optimal protocols remain insufficiently explored. Furthermore, studies comparing fasting with other nutritional medicine approaches (e.g., ketogenic diets) are absent.

Methodology of the evidence base

Controlled human studies on intermittent fasting and therapeutic fasting often last 8–12 weeks, with some extending up to 12 months (⁴). Typical endpoints include anthropometric parameters (body weight, BMI, waist circumference), metabolic markers (HbA_{1c}, fasting blood glucose, insulin resistance), and cardiovascular risk factors (blood pressure, lipids). Some studies also examined liver parameters (IHTG, liver enzymes) or inflammatory markers (CRP, cytokines). Systematic weaknesses include the lack of blinding (nearly all studies), small sample sizes in many studies, and the absence of standardised nutritional protocols. Additionally, long-term studies (>12 months) assessing the sustainability of effects and potential risks (e.g., muscle loss, malnutrition) are lacking. **Hypothesis:** Future studies should incorporate objective compliance measurements (e.g., continuous glucose monitoring) and longer follow-up periods to better evaluate the clinical relevance of fasting interventions.

Fasting as therapy: What the studies can truly support

The evidence suggests a

BROAD EFFICACY

of fasting methods, but the evidence is application-specific. In **obesity** and **type 2 diabetes**, controlled studies show consistent effects on **weight loss** and **blood glucose regulation**, though often only in combination with **caloric restriction** or **dietary changes**. The **TREAT studies** (2020, 2022) demonstrate benefits of **early time-restricted eating**, but **sustainability** beyond 12 months remains unclear. For **cardiovascular markers** (e.g., blood pressure, lipids), the effects are **moderate** and not always clinically significant.

For

CHRONIC CONDITIONS

such as cancer or neurodegenerative disorders, the evidence is **still developing and preliminary**. **Oncological studies** typically examine fasting as **adjuvant therapy**, not as a standalone treatment. The **mechanisms** (e.g., autophagy, IGF-1 reduction) are well-documented in laboratory settings, but their **translation to humans** remains speculative. Furthermore, **comparisons with established therapies** (e.g., pharmacological diabetes treatment) are lacking. **Safety data** are robust for healthy adults, but caution is warranted in **high-risk groups** (e.g., underweight individuals, pregnant women).

3. How Robust the Research Is

Research on therapeutic and intermittent fasting includes **controlled human studies**, with an emphasis on **metabolic parameters** and **safety**. Additional endpoints examined include **fatigue scores**, **cardiovascular markers**, and **inflammatory markers**. Oncology, gut health, and cognition are less represented. The most frequently cited studies assess **weight loss**, **blood glucose regulation**, and **liver fat reduction**, often in randomised designs involving overweight individuals or diabetics.

Methodologically, the studies are **heterogeneous**: While some are **randomised-controlled** with large sample sizes (e.g., the TREAT study), **long-term data** or **placebo controls** are often missing. Many studies measure **surrogate endpoints** (e.g., HbA_{1c}, liver enzymes) rather than clinical outcomes. Additionally, **confounders** such as concurrent dietary changes or physical activity are difficult to control. **Review articles** highlight consistent effects on **weight** and **insulin resistance** but caution against **overinterpretation** in complex conditions like cancer or neurodegenerative disorders.

4. Common Claims — and What the Data Actually Show

STATEMENT	EVIDENCE
Fasting demonstrably reduces inflammatory markers.	Controlled studies demonstrate short-term reductions in inflammatory markers (e.g., CRP), though the clinical relevance remains unclear. Long-term data are
Intermittent fasting is superior to conventional diets.	Studies frequently compare fasting variants with calorie restriction , rather than with other dietary approaches. Weight loss outcomes are similar, while compli
Fasting improves cognitive performance.	The data available is still emerging . Observed effects on attention or memory are inconsistent and often tied to small sample sizes.
Fasting has anti-cancer effects.	The majority of studies are preclinical or examine fasting as a supportive therapy . No controlled study demonstrates an antitumour effect as monotherapy.

5. The Most Robust Studies

Ranked by evidential strength, not by popularity. The full evaluation includes significantly more studies; only the most reliable are listed here.

Controlled Human Studies

- ¹ Effects of Time-Restricted Eating on Weight Loss and Other Metabolic Parameters in Women and Men With Overweight and Obesity: The TREAT Randomized Clinical Trial (2020)
- ² Effectiveness of Early Time-Restricted Eating for Weight Loss, Fat Loss, and Cardiometabolic Health in Adults With Obesity: A Randomized Clinical Trial (2022)
- Feasibility of time-restricted eating and impacts on cardiometabolic health in 24-h shift workers: The Healthy Heroes randomised controlled trial (2022)
- ³ Time-restricted feeding improves blood glucose and insulin sensitivity in overweight patients with type 2 diabetes: a randomised controlled trial (2021)
- Intermittent fasting in the prevention and treatment of cancer (2021)
- ⁴ Effects of Time-Restricted Eating on Nonalcoholic Fatty Liver Disease: The TREATY-FLD Randomised Clinical Trial (2023)
- ⁵ Intermittent fasting plus early time-restricted eating versus calorie restriction and standard care in adults at risk of type 2 diabetes: a randomised controlled trial (2023)
- ⁶ Effect of Time-Restricted Eating on Weight Loss in Adults With Type 2 Diabetes: A Randomised Clinical Trial (2023)
- ⁷ Three weeks of time-restricted eating improves glucose homeostasis in adults with type 2 diabetes but does not improve insulin sensitivity: a randomised controlled trial (2022)
- ⁸ Early time-restricted eating compared with daily caloric restriction: A randomised trial in adults with obesity (2022)
- Gut microbiome remodelling and metabolomic profile improve in response to protein pacing with intermittent fasting versus continuous caloric restriction: a randomised controlled trial (2024)
- ⁹ Effects of time-restricted feeding (16/8) combined with a low-sugar diet on the management of non-alcoholic fatty liver disease: A randomised controlled trial (2023)
- Effects of Intermittent Energy Restriction Compared with Those of Continuous Energy Restriction on Body Composition and Cardiometabolic Risk Markers —A Randomised Controlled Trial (2024)
- ¹⁰ Time-Restricted Eating in Adults With Metabolic Syndrome: A Randomised Controlled Trial (2024)
- Effects of Intermittent Fasting in Humans Compared to a Non-Intervention Diet and Caloric Restriction: A Meta-Analysis of Randomised Controlled Trials (2022)
- ¹¹ Effects of early, late and self-selected time-restricted eating on visceral adipose tissue and cardiometabolic health in participants with overweight: a randomised controlled trial (2025)
- Intermittent fasting and time-restricted eating role in dietary interventions and precision nutrition (2022)
- Time-Limited Eating and Continuous Glucose Monitoring in Adolescents with Obesity: A Pilot Study (2021)
- ¹² The effects of time-restricted eating versus habitual diet on inflammatory cytokines and adipokines in the general adult population: a systematic review and meta-analysis (2024)
- Dietary Interventions in Cancer Treatment and Response: A Comprehensive Review (2022)
- ¹³ Time-Restricted Eating Improves Quality of Life Measures in Overweight Humans (2021)
- ¹⁴ The Impact of a Self-Selected Time-Restricted Eating Intervention on Eating Patterns, Sleep, and Late-Night Eating in Individuals with Obesity (2022)

- ¹⁵ Impact of Early Time-Restricted Eating on Diet Quality, Meal Frequency, Appetite, and Eating Behaviours: A Randomised Trial (2023)
- ¹⁶ Comparing the Effects of Time-Restricted Eating on Glycaemic Control in People with Type 2 Diabetes with Standard Dietetic Practice: A Randomised Controlled Trial (2024)

6. Summary

Therapeutic fasting and intermittent fasting have been studied in controlled human trials, particularly in metabolic disorders such as obesity, type 2 diabetes, and non-alcoholic fatty liver disease (NAFLD). The data consistently demonstrate effects on weight loss, insulin resistance (HOMA-IR), HbA_{1c} reduction, and metabolic parameters such as liver fat content (IHTG). The findings are particularly robust for 16:8 intermittent fasting, which has shown significant improvements compared to control groups in multiple randomised studies. Cardiovascular markers such as blood pressure and lipids also benefit moderately, though the effects are not always clinically relevant. The safety of these methods has been established in short-term studies involving healthy adults and metabolically compromised populations; however, systematic investigations into risks such as muscle loss or malnutrition with longer-term use are lacking.

HYPOTHESIS The combination of time restriction and caloric reduction may have synergistic effects that extend beyond mere caloric restriction, such as synchronisation with the circadian rhythm or modulation of the gut microbiome. This could explain the observed improvements in inflammatory markers (e.g., IL-6) and gastrointestinal symptoms. **Hypothesis:** In oncology, fasting could serve as an adjuvant therapy for certain cancers, for example, to reduce haematotoxicity during chemotherapy or to improve quality of life. However, the underlying mechanisms (e.g., autophagy, IGF-1 reduction) have not yet been sufficiently validated in humans. **Hypothesis:** The applicability of preclinical findings to chronic conditions such as neurodegenerative disorders or cancer remains speculative, as clinical studies are either lacking or exhibit methodological limitations (e.g., small sample sizes, lack of blinding).

Future studies must address several key questions: 1) **Long-term effects and safety:** Are the metabolic effects sustainable (>12 months), and what risks (e.g., muscle loss, malnutrition) exist with prolonged use? 2) **Standardisation of protocols:** Which fasting regimens (e.g., eating windows, fasting duration) are optimal for specific populations (e.g., individuals with diabetes, cancer patients)? 3) **Mechanistic validation:** How do fasting methods affect humans at the molecular level (e.g., autophagy, gut microbiome), and can these effects be harnessed therapeutically? 4) **Comparisons with established therapies:** How do fasting methods compare directly with pharmacological or other nutritional approaches (e.g., ketogenic diets)? 5) **Risk groups:** Which patient groups (e.g., underweight individuals, pregnant women) benefit or are at risk, and how can individual risks be minimised? Methodologically, studies should incorporate objective compliance measurements (e.g., continuous glucose monitoring) and longer follow-up periods to better assess clinical relevance.

7. Unresolved Questions

- **Long-term effects:** Are there sustained benefits beyond 2 years, or do **rebound effects** occur?
- **Individual variability:** Why do some patients respond **strongly** to fasting, while others show **no response** at all?
- **Combination therapies:** Can fasting be used synergistically with **medications** (e.g., antidiabetics) or **exercise**?

Frequently Asked Questions

Is intermittent fasting suitable for patients with type 2 diabetes?

Controlled studies demonstrate **improvements** in **blood glucose** and **insulin resistance**, particularly with **early time-restricted eating** (e.g., 16:8). However, **dose adjustments** for antidiabetic medications are necessary, as the **risk of hypoglycaemia** increases. **Long-term compliance** is often poor. **Recommendation:** Only undertake under **medical supervision**.

Can therapeutic fasting help with rheumatoid arthritis?

The evidence base is **still developing**. **Observational studies** report **symptomatic improvements**, but the **mechanisms** remain unclear. Potential effects may be attributed to **weight loss** or **anti-inflammatory actions**. **No evidence** supports a **disease-modifying effect**.

How safe is fasting for older patients?

The **safety data** primarily derive from studies involving **younger adults**. In older individuals, there is an **increased risk** of **muscle loss**, **electrolyte imbalances**, or **falls**. **Contraindications** include **underweight**, **eating disorders**, or **advanced dementia**. **Recommendation:** Only undertake under **close monitoring** and with **adequate protein intake** during eating periods.

Sources

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Research, put in context. Every statement leads to the original paper; the decision in the individual case rests with the treating professional.
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