Are retinol, vitamin C, vitamin E, folate and carotenoids intake associated with bladder cancer risk? Results from the Netherlands Cohort Study

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Summary In the Netherlands Cohort Study among 120 852 subjects aged 55–66 years at baseline (1986), the association between vitamins and carotenoids intake, vitamin supplement use, and bladder cancer incidence was examined. Exposure status was measured with a food-frequency questionnaire. After 8.3 years of follow-up, data from 569 cases and 3123 subcohort members were available for case-cohort analyses. The age-, sex-, and smoking-adjusted relative risks (RRs) for retinol, vitamin E, folate, α-carotene, β-carotene, lutein and zeaxanthin, and lycopene were 1.04, 0.98, 1.03, 0.99, 1.16, 1.11, and 1.06, respectively, comparing highest to lowest quintile of intake. Only vitamin C (RR: 0.81, 95% CI: 0.61–1.07, P-trend = 0.08), and β-cryptoxanthin intake (RR: 0.74, 95% CI: 0.53–1.03, P-trend < 0.01) were inversely associated with bladder cancer risk. The association with vitamin C disappeared after adjustment for β-cryptoxanthin but not vice versa. The RRs for supplemental use of vitamin A, C or E compared to no use were around unity.

We conclude that dietary or supplemental intake of vitamin A, vitamin C, vitamin E, and intake of folate, and most carotenoids are not associated with bladder cancer. In this study, only β-cryptoxanthin intake appeared to be inversely associated. © 2001 Cancer Research Campaign http://www.bjcancer.com

Keywords: urologic neoplasms; bladder neoplasms; vitamin-A; vitamin-C; vitamin-E; folate; carotenoids

Bladder cancer is the most common urological cancer, and is the seventh most common cancer among men, accounting for approximately 200 000 new cases per year worldwide (Parkin et al., 1999). Over the last four decades, many epidemiological studies and several reviews have been conducted to investigate determinants of bladder cancer (Johansson and Coheen, 1997; Ross et al., 1996; Silverman et al., 1992; van der Meijden, 1998; World Cancer Research Fund & American Institute for Cancer Research, 1997). These studies suggested that bladder cancer is influenced by environmental factors, including cigarette smoking, fluid consumption, schistosomal infections, exposure to industrial chemicals (e.g. aromatic amines) and diet.

Among the dietary factors, it has been suggested that vegetable and fruit consumption may protect against cancer at various anatomical sites. With respect to bladder cancer, most epidemiological studies support a possible protective effect of vegetable (Bruemmer et al., 1996; D'Avanzo et al., 1995; Michaud et al., 1999; Mills et al., 1991; Negri et al., 1991) and fruit consumption (Bruemmer et al., 1996; Chyou et al., 1993; Negri et al., 1991; Shibata et al., 1992), although some studies have reported no association for vegetable (Riboli et al., 1991; Shibata et al., 1992) or fruit consumption (Michaud et al., 1999; Riboli et al., 1991). There are many candidate agents in fruits and vegetables that influence bladder cancer risk, including carotenoids, vitamin C, vitamin E, and folate.

In the present prospective study, we were able to explore the influence of the intake of different vitamins (i.e. retinol, vitamin C, vitamin E, and folate), and the use of vitamin-containing supplements on bladder cancer risk with substantially more cases than in previous studies. Furthermore, with the use of a recently developed food composition table on carotenoids in Dutch foods (1996), analyses were performed with α-carotene, β-carotene, lutein plus zeaxanthin, β-cryptoxanthin, and lycopene.

MATERIALS AND METHODS

Cohort

The study design has been described in detail previously (van den Brandt et al., 1990a). The cohort includes 58 279 men and 62 573 women aged 55–69 years at baseline (1986). The study population originated from 204 municipal population registries throughout the country. The case cohort approach was used for data processing and analysis (Prentice, 1986). Following this approach, a subcohort of 3500 subjects (1688 men, 1812 women) was randomly sampled from the cohort after baseline exposure measurement. The subcohort has been followed up for vital status information. No subcohort members were lost to follow-up.

Follow-up

Follow-up for incident cancer was established by record linkage to cancer registries and the Dutch national database of pathology reports (van den Brandt et al., 1990b). The completeness of cancer follow-up was estimated to be over 95% (Goldbohm et al., 1994b). The presented analysis is restricted to cancer incidence in 6.3 years
of follow-up. After excluding prevalent cases with cancer other than skin cancer a total of 3346 subcohort members (1630 men and 1716 women) and 619 incident cases (532 men and 87 women) with microscopically confirmed, incident carcinomas of the urinary bladder, ureters, renal pelvis or urethra were identified. Of these cases, 584 (94.3%) were diagnosed with bladder cancer of which 559 (95.7%) were transitional cell carcinomas. Because the overwhelming majority of tumours occurred in the urinary bladder and the ureters, renal pelvis, and urethra are covered by the same urothelium as the urinary bladder, the term bladder cancer is used as a synonym for these neoplasms.

Exposure status

At baseline, the cohort members completed a mailed, self-administered questionnaire on risk factors for cancer. Usual consumption of food and beverages during the year preceding the start of the study was assessed with a 150-item semi-quantitative food frequency questionnaire. The questionnaire was validated against a 9-day diet record. The energy and sex-adjusted Pearson correlation coefficients between the 9-day record and the questionnaire were 0.48 for total vitamin A and 0.55 for vitamin C (Goldbohm et al., 1994a). The questionnaire data were key entered twice and processed in a standardized manner blinded with respect to case/subcohort status in order to minimize observer bias in coding and interpretation of the data. In this study, variables of principle interest were retinol, vitamins C and E, folate, several carotenoids and the use of vitamin-containing supplements. The mean daily intake of retinol, vitamins C and E were calculated using the computerized Dutch Food Composition Table (1986). Folate data were derived from a validated liquid chromatography trienzyme method with which the most important Dutch foods contributing to folate intake were analysed (Koning, 1999). For calculating the intake of specific carotenoids an additional food composition table has been constructed recently (Goldbohm et al., 1998). Briefly, regularly eaten vegetables were comprehensively sampled and analysed for their carotenoid content and the database was completed with data from the recent literature and information from food manufacturers (Goldbohm et al., 1998). With this carotenoid table, we were able to evaluate six of the most important types of carotenoids: \( a \)-carotene, \( b \)-carotene, lycopene, \( b \)-cryptoxanthin, and lutein/zeaxanthin were comparable between cases and sub-cohort members. The intake of vitamin C and the use of supplements containing vitamin A, C or E were higher among sub-cohort members than among cases. Of the potential confounders, the distribution of age, total water, alcohol, coffee, tea, total vegetable, and total fruit consumption was similar for cases and sub-cohort members. More than 80% of the cases were male, whereas in the sub-cohort approximately 50% were male. Cigarette use was more often reported in cases than in sub-cohort members and smoking cases appeared to smoke more cigarettes per day for more years than smoking sub-cohort members. Less than 2% of the cases and sub-cohort members reported a family history of bladder cancer or had ever worked in a high-risk occupation (Table 1).

The association between vitamin and carotenoid intake and bladder cancer risk was similar in men and women for all vitamins and carotenoids (data not shown). Therefore, the results are presented for men and women combined. As is shown in Table 2, except for vitamin C intake, none of the vitamins (retinol, vitamin E, and folate), appeared to be associated with bladder cancer risk. The age- and sex-adjusted RR of bladder cancer for quintiles 2 and 3 combined and quintiles 4 and 5 combined of vitamin C intake were 0.77 (CI: 0.61–0.98) and 0.74 (CI: 0.58–0.95) compared to the lowest quintile of intake, respectively (P-trend < 0.01). Although cigarette smoking amount and cigarette smoking duration are important determinants of bladder cancer, adjustment

## RESULTS

Table 1 presents the distribution of the dietary and supplemental vitamin intakes and the distribution of potential confounding factors among bladder cancer cases and sub-cohort members. The dietary intakes of retinol, vitamin E, folate, \( a \)-carotene, \( b \)-carotene, lycopene, \( b \)-cryptoxanthin, and lutein/zeaxanthin were comparable between cases and sub-cohort members. The intake of vitamin C and the use of supplements containing vitamin A, C or E were higher among sub-cohort members than among cases. Of the potential confounders, the distribution of age, total water, alcohol, coffee, tea, total vegetable, and total fruit consumption was similar for cases and sub-cohort members. More than 80% of the cases were male, whereas in the sub-cohort approximately 50% were male. Cigarette use was more often reported in cases than in sub-cohort members and smoking cases appeared to smoke more cigarettes per day for more years than smoking sub-cohort members. Less than 2% of the cases and sub-cohort members reported a family history of bladder cancer or had ever worked in a high-risk occupation (Table 1).

The association between vitamin and carotenoid intake and bladder cancer risk was similar in men and women for all vitamins and carotenoids (data not shown). Therefore, the results are presented for men and women combined. As is shown in Table 2, except for vitamin C intake, none of the vitamins (retinol, vitamin E, and folate), appeared to be associated with bladder cancer risk. The age- and sex-adjusted RRs of bladder cancer for quintiles 2 and 3 combined and quintiles 4 and 5 combined of vitamin C intake were 0.77 (CI: 0.61–0.98) and 0.74 (CI: 0.58–0.95) compared to the lowest quintile of intake, respectively (P-trend < 0.01). Although cigarette smoking amount and cigarette smoking duration are important determinants of bladder cancer, adjustment
Table 1 Description of mean daily intake of vitamins, carotenoids and vitamin supplement use and distribution of potential confounding factors, Netherlands Cohort Study (1986–1992)

<table>
<thead>
<tr>
<th>Exposure variables</th>
<th>Cases (n = 569)</th>
<th>Sub-cohort (n = 3123)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Retinol (mg/day)</td>
<td>0.59</td>
<td>0.23</td>
</tr>
<tr>
<td>Vitamin C (mg/day)</td>
<td>97.0</td>
<td>44.1</td>
</tr>
<tr>
<td>Vitamin E (mg/day)</td>
<td>13.9</td>
<td>5.27</td>
</tr>
<tr>
<td>Folate (mg/day)</td>
<td>219</td>
<td>73.7</td>
</tr>
<tr>
<td>α-carotene (mg/day)</td>
<td>0.86</td>
<td>0.40</td>
</tr>
<tr>
<td>β-carotene (mg/day)</td>
<td>2.69</td>
<td>1.42</td>
</tr>
<tr>
<td>Lycopene (mg/day)</td>
<td>1.14</td>
<td>1.94</td>
</tr>
<tr>
<td>β-cryptoxanthin (mg/day)</td>
<td>0.15</td>
<td>0.20</td>
</tr>
<tr>
<td>Lutein/neoxanthin (mg/day)</td>
<td>2.54</td>
<td>1.23</td>
</tr>
<tr>
<td>Use of supplements containing vitamin A (% yes)</td>
<td>30</td>
<td>5.27</td>
</tr>
<tr>
<td>Use of supplements containing vitamin C (% yes)</td>
<td>48</td>
<td>8.44</td>
</tr>
<tr>
<td>Use of supplements containing vitamin E (% yes)</td>
<td>28</td>
<td>4.92</td>
</tr>
<tr>
<td>Potential confounding factors</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Age (years)</td>
<td>62.7</td>
<td>4.07</td>
</tr>
<tr>
<td>Total water consumption (l/day)</td>
<td>2.13</td>
<td>0.52</td>
</tr>
<tr>
<td>Alcohol consumption (g/day)</td>
<td>18.2</td>
<td>18.2</td>
</tr>
<tr>
<td>Coffee consumption (cups/day)</td>
<td>4.80</td>
<td>2.39</td>
</tr>
<tr>
<td>Tea consumption (cups/day)</td>
<td>2.45</td>
<td>2.02</td>
</tr>
<tr>
<td>Total vegetable consumption (g/day)</td>
<td>196</td>
<td>92.4</td>
</tr>
<tr>
<td>Total fruit consumption (g/day)</td>
<td>151</td>
<td>200</td>
</tr>
<tr>
<td>Cigarette smoking amount (cig/day)*</td>
<td>18.7</td>
<td>11.3</td>
</tr>
<tr>
<td>Cigarette smoking duration (years)*</td>
<td>37.5</td>
<td>11.6</td>
</tr>
</tbody>
</table>

| Sex (% male)                        | 461           | 86.3                 | 1525          | 48.8                 |
| Cigarette smoking status (% current) | 255           | 44.8                 | 875           | 28.0                 |
| Cigarette smoking status (% never)  | 62            | 10.9                 | 1147          | 37.7                 |
| Family history of bladder cancer (% yes) | 7            | 12.3                 | 60            | 1.89                 |
| High risk occupation (% yes)        | 4             | 0.70                 | 15            | 0.48                 |

*Among smokers: 1ever exposed to dye, rubber, leather, and vehicle fumes.

Table 2 Incidence rate ratios and 95% confidence intervals for bladder cancer according to quintiles of intake of retinol, vitamins C and E, and folate, Netherlands Cohort Study (1986–1992)

<table>
<thead>
<tr>
<th>Quintiles of Intake</th>
<th>Vitamins</th>
<th>Cases</th>
<th>1 (low)*</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (high)</th>
<th>P-trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinol</td>
<td>Median intake (mg/day)</td>
<td>0.26</td>
<td>0.38</td>
<td>0.48</td>
<td>0.61</td>
<td>0.87</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 1</td>
<td>569</td>
<td>1.00</td>
<td>0.75 (0.54–1.08)</td>
<td>0.95 (0.69–1.30)</td>
<td>0.96 (0.72–1.33)</td>
<td>0.92 (0.89–1.26)</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 2</td>
<td>475</td>
<td>1.00</td>
<td>0.83 (0.56–1.24)</td>
<td>1.04 (0.72–1.51)</td>
<td>1.02 (0.71–1.46)</td>
<td>1.04 (0.72–1.48)</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>Vitamin C</td>
<td>Median intake (mg/day)</td>
<td>54.9</td>
<td>86.6</td>
<td>135</td>
<td>6.59</td>
<td>2.7</td>
<td>21.7</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 1</td>
<td>569</td>
<td>1.00</td>
<td>0.77 (0.61–0.98)</td>
<td>0.74 (0.64–0.86)</td>
<td>&lt; 0.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 2</td>
<td>475</td>
<td>1.00</td>
<td>0.87 (0.68–1.14)</td>
<td>0.81 (0.61–1.07)</td>
<td>0.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin E</td>
<td>Median intake (mg/day)</td>
<td>6.59</td>
<td>9.27</td>
<td>12.2</td>
<td>16.8</td>
<td>21.7</td>
<td>0.46</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 1</td>
<td>569</td>
<td>1.00</td>
<td>0.99 (0.72–1.36)</td>
<td>1.08 (0.79–1.48)</td>
<td>1.05 (0.77–1.43)</td>
<td>0.78 (0.85–1.22)</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 2</td>
<td>475</td>
<td>1.00</td>
<td>1.10 (0.76–1.61)</td>
<td>1.28 (0.90–1.84)</td>
<td>1.11 (0.77–1.59)</td>
<td>0.98 (0.88–1.41)</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Folate</td>
<td>Median intake (mg/day)</td>
<td>0.14</td>
<td>0.17</td>
<td>0.20</td>
<td>0.23</td>
<td>0.29</td>
<td>0.77</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 1</td>
<td>569</td>
<td>1.00</td>
<td>0.80 (0.58–1.10)</td>
<td>0.80 (0.59–1.08)</td>
<td>0.72 (0.53–0.98)</td>
<td>0.93 (0.70–1.25)</td>
<td>0.55</td>
<td></td>
</tr>
<tr>
<td>RR (95% CI)* 2</td>
<td>475</td>
<td>1.00</td>
<td>0.87 (0.69–1.23)</td>
<td>0.67 (0.42–1.14)</td>
<td>0.92 (0.68–1.17)</td>
<td>1.03 (0.75–1.44)</td>
<td>0.77</td>
<td></td>
</tr>
</tbody>
</table>

*Reference category; 1adjusted for age (years) and sex; 2adjusted for age (years); sex, cigarette smoking amount (cig/day) and cigarette smoking duration (years); for vitamin C, quintiles 2 and 3 and quintiles 4 and 5 were combined.
Table 3: Incidence rate ratios and 95% confidence intervals for bladder cancer according to quintiles of intake of carotenoids, Netherlands Cohort Study (1986-1992)

<table>
<thead>
<tr>
<th>Carotenoids</th>
<th>No. of cases</th>
<th>1 (low)*</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (high)</th>
<th>P-trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>α-Carotene</td>
<td>Median intake (mg/day)</td>
<td>0.19</td>
<td>0.38</td>
<td>0.57</td>
<td>0.82</td>
<td>1.31</td>
<td>0.27</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>569</td>
<td>1.00</td>
<td>0.63-1.13</td>
<td>0.55-1.10</td>
<td>0.90-1.20</td>
<td>0.83-1.11</td>
<td>0.61-1.11</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>475</td>
<td>1.00</td>
<td>0.59-1.13</td>
<td>0.54-1.10</td>
<td>0.80-1.16</td>
<td>0.99-1.39</td>
<td>0.71-1.39</td>
</tr>
<tr>
<td>β-Carotene</td>
<td>Median intake (mg/day)</td>
<td>1.45</td>
<td>2.10</td>
<td>2.65</td>
<td>3.37</td>
<td>4.76</td>
<td>0.67</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>569</td>
<td>1.00</td>
<td>1.04-1.39</td>
<td>0.87-1.18</td>
<td>0.89-1.20</td>
<td>0.96-1.32</td>
<td>0.73-1.32</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>475</td>
<td>1.00</td>
<td>1.07-1.49</td>
<td>0.90-1.27</td>
<td>0.93-1.32</td>
<td>1.16-1.63</td>
<td>0.92-1.63</td>
</tr>
<tr>
<td>Lutein and zeaxanthin</td>
<td>Median intake (mg/day)</td>
<td>1.34</td>
<td>1.86</td>
<td>2.34</td>
<td>2.84</td>
<td>3.82</td>
<td>0.49</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>569</td>
<td>1.00</td>
<td>0.97-1.31</td>
<td>0.86-1.16</td>
<td>0.84-1.13</td>
<td>1.02-1.37</td>
<td>0.76-1.37</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>475</td>
<td>1.00</td>
<td>1.00-1.41</td>
<td>0.86-1.26</td>
<td>0.99-1.40</td>
<td>1.11-1.57</td>
<td>0.75-1.57</td>
</tr>
<tr>
<td>β-Cryptoxanthin</td>
<td>Median intake (mg/day)</td>
<td>0.02</td>
<td>0.06</td>
<td>0.13</td>
<td>0.25</td>
<td>0.40</td>
<td>0.01</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>569</td>
<td>1.00</td>
<td>0.03-0.83</td>
<td>0.04-0.72</td>
<td>0.09-0.80</td>
<td>0.71-0.95</td>
<td>0.53-0.95</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>475</td>
<td>1.00</td>
<td>0.70-0.95</td>
<td>0.56-0.78</td>
<td>0.62-0.87</td>
<td>0.74-1.03</td>
<td>0.53-1.03</td>
</tr>
<tr>
<td>Lycopene</td>
<td>Median intake (mg/day)</td>
<td>0.15</td>
<td>0.48</td>
<td>0.81</td>
<td>1.21</td>
<td>2.21</td>
<td>0.58</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>569</td>
<td>1.00</td>
<td>0.62-1.11</td>
<td>1.07-1.42</td>
<td>1.05-1.41</td>
<td>0.97-1.31</td>
<td>0.72-1.31</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>475</td>
<td>1.00</td>
<td>0.61-1.18</td>
<td>1.07-1.48</td>
<td>1.18-1.65</td>
<td>1.08-1.51</td>
<td>0.77-1.51</td>
</tr>
</tbody>
</table>

*Reference category; *adjusted for age (years) and sex; **adjusted for age (years), sex, cigarette smoking amount (cig/day) and cigarette smoking duration (years).

for these covariates increased the risk estimates not essentially (Table 2). Also, adjustment for other potential confounders did not substantially change the risk estimates (data not shown).

The intake of the carotenoids α-carotene, β-carotene, lutein/zeaxanthin, and lycopene was not associated with bladder cancer risk (Table 3). The intake of β-cryptoxanthin appeared to be inversely associated with bladder cancer risk (p-trend < 0.01) with corresponding age- and sex adjusted RR per increasing quintiles of intake of 1.00 (reference), 0.63 (CI: 0.48-0.83), 0.54 (CI: 0.40-0.72), 0.59 (CI: 0.44-0.80) and 0.71 (CI: 0.53-0.95), respectively. Adjustment for cigarette smoking or other potential confounders did not change the results substantially (Table 3).

Since the intake of vitamin C and β-cryptoxanthin were correlated (r = 0.69), and both vitamin C and β-cryptoxanthin were inversely associated with bladder cancer risk (Tables 2 and 3) we estimated the incidence rate ratios for both nutrients after adjustment for each other in addition to age, sex, cigarette smoking amount and cigarette smoking duration (Table 4). After adjustment for β-cryptoxanthin intake, the inverse association for vitamin C intake disappeared. However, the RR for β-cryptoxanthin intake did not change essentially after adjustment for vitamin C intake (Table 4).

We investigated potential effect modification of the association between β-cryptoxanthin and bladder cancer risk by cigarette smoking amount and duration (Table 5). We found a statistically significant interaction effect with smoking amount (P < 0.01) but not with smoking duration (P = 0.10). The inverse association between β-cryptoxanthin and bladder cancer risk was not found among non-smokers and appeared to be limited to cigarette smokers who smoked more than 15 cigarettes per day or who smoked for more than 35 years (Table 5).

The protective effect of β-cryptoxanthin intake was observed in each stratum of tumour invasiveness or morphology of male transitional cell carcinomas of the bladder, although the association was less pronounced for non-invasive papillary tumours (Table 6).

Table 4: Incidence rate ratios and 95% confidence intervals for bladder cancer according to quintiles of vitamin C and β-cryptoxanthin adjusted for each other, Netherlands Cohort Study (1986-1992)

<table>
<thead>
<tr>
<th>Quintiles of intake</th>
<th>1 (low)*</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (high)</th>
<th>P-trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin C*</td>
<td>1.00</td>
<td>1.08</td>
<td>1.07</td>
<td>1.07</td>
<td>0.73-1.57</td>
<td>0.67</td>
</tr>
<tr>
<td>RR (95% CI)*</td>
<td>1.00</td>
<td>0.69-0.83</td>
<td>0.54-0.78</td>
<td>0.80-0.89</td>
<td>0.71-1.11</td>
<td>0.01</td>
</tr>
<tr>
<td>β-Cryptoxanthin</td>
<td>1.00</td>
<td>0.69-0.83</td>
<td>0.54-0.78</td>
<td>0.80-0.89</td>
<td>0.71-1.11</td>
<td>0.01</td>
</tr>
</tbody>
</table>

*Reference category; *for vitamin C, quintiles 2 and 3 and quintiles 4 and 5 were combined; **adjusted for age (years), sex, cigarette smoking amount (cig/day), cigarette smoking duration (years) and β-cryptoxanthin intake; ***adjusted for age (years), sex, cigarette smoking amount (cig/day), cigarette smoking duration (years) and vitamin C intake.
The risks of bladder cancer for consumers of vitamin supplements containing vitamin A, vitamin C or Vitamin E were similar to the risk for non-consumers. After adjustment for age, sex, cigarette smoking amount and cigarette smoking duration the RRs were 1.12 (CI: 0.71–1.78), 1.01 (CI: 0.69–1.48), and 1.05 (CI: 0.63–1.73), respectively (data not shown).

DISCUSSION

The results of the prospective Netherlands Cohort Study showed that, in general, the intake of retinol, vitamin C, vitamin E, folic acid, carotenoids, and the use of vitamin supplements are not associated with bladder cancer risk. The initial inverse association with vitamin C intake disappeared after controlling for β-cryptoxanthin intake. Only β-cryptoxanthin intake appeared to be inversely associated with bladder cancer risk, especially among heavy cigarette smokers.

The NLCS was carried out in the general Dutch population of men and women aged 55–69 years at baseline. After 6.3 years of follow-up, 569 bladder cancer cases were detected which is substantially more than any other prospective study that investigated the association between these nutrients, and the risk of bladder cancer. The prospective nature of a cohort study together with completeness of follow-up, as has been achieved in this study, reduced the potential for selection bias to a minimum. Non-differential misclassification of exposure, may have resulted in underestimation of the strength of the association. However, the results of the validation study showed that the questionnaire was able to rank subjects adequately according to their intake of most nutrients. In a reproducibility study, it was further demonstrated that the single food frequency questionnaire measurement could characterize dietary habits for a period of at least 5 years (Goldbloom et al., 1995). Information bias is also largely avoided because dietary habits were reported before bladder cancer was diagnosed. A change in dietary habits of subjects with latent bladder cancer at the time of completing the baseline questionnaire is much less likely than in subjects with, e.g. gastrointestinal cancer. Furthermore, repeating analyses after excluding cases diagnosed in the first 1 or 2 years hardly affected our results.

A potentially more realistic problem in evaluating the observed inverse associations is residual confounding by cigarette smoking. We modelled cigarette smoking habits such that they best explained bladder cancer (Zeegers et al., 2000b). This resulted in a model including number of years smoked and habitual number of cigarettes smoked per day, both as continuous variables. We therefore believe that the associations observed were not entirely due to residual confounding by smoking, although we cannot exclude some influence. When we added the smoking variables to an age- and sex-adjusted model, the RR estimates changed only slightly. We were not able to explain our results on the basis of confounding of other factors in addition to cigarette smoking, since our results were essentially unchanged after incorporating into the analyses many known or suspected risk factors for bladder cancer, including total consumption of alcohol, coffee, tea, and water, high risk occupation, and family history of bladder cancer.

Table 5 Incidence rate ratios and 95% confidence intervals for bladder cancer according to β-cryptoxanthin intake, with respect to cigarette smoking amount and duration; Netherlands Cohort Study (1986–1992)

<table>
<thead>
<tr>
<th>Cigarette smoking</th>
<th>Quintiles of β-cryptoxanthin intake</th>
<th>P-trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (low)*</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Amount (cig/day)</td>
<td>&lt; 15</td>
<td>1.00</td>
</tr>
<tr>
<td>15+</td>
<td>1.00</td>
<td>0.86 (0.47–1.00)</td>
</tr>
<tr>
<td>Duration (years)*</td>
<td>&lt; 35</td>
<td>1.00</td>
</tr>
<tr>
<td>35+</td>
<td>1.00</td>
<td>0.67 (0.46–0.99)</td>
</tr>
</tbody>
</table>

*Reference category; *adjusted for age and sex; *adjusted for age (years), sex, and cigarette smoking duration (years); *adjusted for age (years), sex, and cigarette smoking amount (cig/day).

Table 6 Incidence rate ratios and 95% confidence intervals for transitional cell carcinoma of the urinary bladder according to β-cryptoxanthin intake, with respect to tumour invasiveness and morphology; Netherlands Cohort Study (1986–1992)

<table>
<thead>
<tr>
<th>β-cryptoxanthin (quintiles of Intake)</th>
<th>Non-papillary (n = 24)* RR (95% CI)*</th>
<th>Papillary (n = 232)# RR (95% CI)#</th>
<th>Non-papillary (n = 111)* RR (95% CI)*</th>
<th>Papillary (n = 146)# RR (95% CI)#</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (low)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
<td>1.00 (reference)</td>
</tr>
<tr>
<td>2</td>
<td>0.28 (0.10–0.93)</td>
<td>1.08 (0.68–1.57)</td>
<td>0.66 (0.37–1.19)</td>
<td>0.66 (0.28–1.26)</td>
</tr>
<tr>
<td>3</td>
<td>0.30 (0.05–1.42)</td>
<td>0.76 (0.47–1.20)</td>
<td>0.54 (0.26–1.02)</td>
<td>0.44 (0.24–0.79)</td>
</tr>
<tr>
<td>4</td>
<td>0.51 (0.14–1.88)</td>
<td>0.82 (0.51–1.33)</td>
<td>0.55 (0.28–0.89)</td>
<td>0.49 (0.27–0.86)</td>
</tr>
<tr>
<td>5 (high)</td>
<td>0.18 (0.02–1.57)</td>
<td>0.48 (0.25–0.88)</td>
<td>0.72 (0.36–1.36)</td>
<td>0.71 (0.41–1.23)</td>
</tr>
<tr>
<td>P-value for linear trend</td>
<td>0.04</td>
<td>0.22</td>
<td>0.11</td>
<td>0.08</td>
</tr>
</tbody>
</table>

ICD-O-M8120, *ICD-O-M8130, *adjusted for age (years), sex, cigarette smoking amount (cig/day), and cigarette smoking duration (years).
Vitamin A is important for cell differentiation and since lack of differentiation is a feature of cancer cells, a protective effect of vitamin A on cancer development may be expected (Kamat and Lamm, 1999; Patterson et al., 1997; Steinmetz and Potter, 1991). Retinol is the physiologically active form of vitamin A and can also be derived from some carotenoids (e.g. α-carotene, β-carotene, and β-cryptoxanthine). Some carotenoids have antioxidant properties and may inhibit carcinogenesis by preventing DNA damage induced by free radicals. However, a recently published meta-analysis based on seven case control studies and three cohort studies did not find increased risks for diets low in retinol or β-carotene (Steinmaus et al., 2000). A prospective study that was published more recently also found no association between supplemental and dietary vitamin A intake and bladder cancer risk (Michaud et al., 2000). In the present study, only the dietary intake of the carotenoid β-cryptoxanthin appeared to be inversely associated with bladder cancer risk. We know of no biological mechanism other than its provitamin A activity that might explain this specific association. Citrus fruits are the main sources of β-cryptoxanthin. In a previous analysis, we also presented an inverse association between citrus fruit consumption and bladder cancer risk (Zeegers, submitted for publication).

However, an earlier study having used a non-informed prospective study did not find an association between β-cryptoxanthin and bladder cancer risk (Michaud et al., 1999). Further research is needed to evaluate this matter.

Vitamin C is mostly known for its antioxidant capacity (Steinmetz and Potter, 1991) and its ability to prevent formation of nitrosamine and other N-nitroso compounds (Birt, 1986). In addition to β-cryptoxanthin, citrus fruits are also known for their high content of vitamin C. After adjustment for β-cryptoxanthin, the small inverse association between vitamin C intake and bladder cancer risk increased towards unity. Two previously conducted population based case-control studies found small increased risks of bladder cancer with increased intake of dietary vitamin C for men and women combined (Risch et al., 1988) or for men only (Nomura et al., 1991) after controlling for cigarette smoking. However, other population based case control studies presented decreased risks for men and women combined (Bruemmer et al., 1996) or for women only (Nomura et al., 1991), or found no association at all (Riboli et al., 1991). One prospective study suggested an inverse association with dose of vitamin C supplement use, but not with dietary vitamin C intake (Michaud et al., 2000), which is in correspondence to the results of the present study.

Sources of β-cryptoxanthin. In a previous analysis, we also presented an inverse association between citrus fruit consumption and bladder cancer risk (Zeegers, submitted for publication).


StataCorp (1995) Stata Statistical Software: Release 6.0. Stata Corporation: College Station, TX