Role of Nutritional Factors in Pathogenesis of Cancer

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Review

Role of nutritional factors in pathogenesis of cancer

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Abstract

Diet and nutrition are crucial factors throughout the complete life course in the promotion and upholding of good health. It has always been accepted that our defencelessness to infection and disease was influenced by diet and environmental as well as genetic factors. Nutrition is coming to the front position as a principle modifiable determinant of chronic disease, with scientific confirmation with time more supporting the view that alterations in diet have strong effects, equally positive as well as negative, on health throughout life. For the most part notably, nutritional adjustments may not only influence present health but also determine whether or not an individual will develop chronic non-communicable diseases like cancer. Diet is a blend of protective, mutagenic, and carcinogenic agents; the majority of them are metabolized by the enzymes of biotransformation process. Genetic polymorphisms that alter protein expression or else the function of these enzymes can change the risk of developing cancer. The scientific community has identified numerous naturally occurring materials in plant food with the power to resolve possible carcinogens. A few of these nutrients and natural phytochemicals look for toxins and usher them from the body before they can cause cell damage that may lead to cancer. Others give the impression to make it easier for the body to make repairs at the cellular level. At a standstill, others may help bring to an end cancer cells from reproducing. Even after a cell begins to experience damage that can lead to cancer, what you eat and drink, and how you live can still help short-circuit the cancer process. It is thought that a diet containing defensive micronutrients as well as carcinogens and mutagens may adapt the risk of cancer development, particularly in genetically susceptible individuals.

Key words: Nutritional factor; Dietary practices; Susceptibility; Cancer.

Introduction

Nutritional factors have been thought responsible for about 30 per cent of cancers in more developed countries, making nutrient secondary only to tobacco as a mendable cause of cancer (Doll, 1981). The share of diet-to-cancer risk in low-income countries has been considered to be lower, perhaps around 20 per cent (Miller, 2001). The relationship between nutritional factors and pathogenesis of cancer first established by an experimental study conducted in 1940s where sequential confinement of nutritional factors markedly reduced the incidence of cancer in mice (Tannenbaum, 1940). After 2 decades other advancement like development of cancer registries and research focused on effect of environmental factors on human health depicts larger picture about the geographical variations in cancer incidence which might be due to the differences in lifestyle and dietary habits (Doll, 1966; Doll, 1970; Armstrong, 1975). It is followed by prominent number of case-control studies in 1970s.
and 1980s to identify nutritional risk factors with greater specificity. Food patterns and specific food components, macro- and micronutrients may all play etiological roles and their effects may also be modified by other lifestyle factors such as physical activity or childbearing patterns. It has been hypothesized that 30%–40% of different subtypes of cancer may preclude with a healthy lifestyle and dietary habits. In some studies, probable associations have suggested with a few nutritional factors, but have focused mostly on the potential increased risks linked with the consumption of eggs, meat, and dairy products and the promising drop in risk connected with high intake of fruit and vegetables (Wolk, 1996; Lindblad, 1997; Handa, 2002; Nicodemus, 2004). Obesity is substantially correlated with carbohydrate and an established risk factor for cancers of the oesophagus (adenocarcinoma) colorectum, breast, endometrium and kidney (International Agency for Research on Cancer, 2002; Key, 2004). Contribution to obesity by dietary carbohydrates after that they nearly without doubt also add to rising the risk for these meticulous cancer sites (van Dam, 2007).

Hormonal and reproductive factors are the established risk factors for breast cancer, and it is obvious that higher intake of sucrose or else higher glycemic load may increase risk leading to obesity which will in turn increase the endogenous oestrogen levels (Key, 2003). Some evidence has led to the suggestion that a high intake of dietary fibre might reduce the risk of breast cancer, colorectal cancer, and stomach cancer (Burkitt, 1969; De Stefani, 1999). Carbohydrates are not considered to be directly pertinent to the aetiology of few types of cancer like liver cancer, lung cancer, ovarian cancer, prostate cancer, and bladder cancer (Jain, 2000; Pandey, 2003; Zeegers, 2004; Chan, 2005). Experimental studies and epidemiological data both indicate that high-fat diets increase the risk of cancer at sites such as breast, colon, prostate and pancreas (Armstrong, 1975; Carroll, 1983; Prentice, 1990). However, these associations are due to correlations with intake of animal fat, not vegetable fat (Rose, 1986). Based on these epidemiological investigations and animal studies, dietary fat increasing has been hypothesized to act by excretion of bile acids, which can be converted to carcinogens or promoters. Dietary polyunsaturated vegetable oils promote tumorigenesis in animals whereas saturated fats and polyunsaturated fish oils either have little effect or are inhibitory. Omega-3 fat acids that are present in fish oils and in some vegetables may reduce the incidence of breast and colon cancer (Carroll, 1991). It seems that monounsaturated oils such as olive oil, behave in a neutral manner. There is much convincing evidence that a high consumption of protein sources such as red and processed meat is associated with increased colorectal cancer risk (World Cancer Research Fund and American Investigation of Cancer Research, 2007). Furthermore, in a controlled trial, a low protein–high protein weight-loss diet has been observed to reduce fecal cancer-protective metabolites and increase hazardous metabolites, which could increase the risk of colon cancer (Russell, 2007). A possible increased risk of respiratory cancer was observed with a tendency of an increased general cancer risk over a shorter time. So cancer is one of the most important diseases that affect people worldwide. Cancer usually is an environmental disease and strongly associated with nutritional factors and precipitated by genetic factors. In this review, we have discussed the role of dietary factors which could have a significant role as a promoter or inhibitor in pathogenesis of different subtypes of cancer worldwide.

Prevalence of cancer

Cancer accounts for approximately 13 per cent of all deaths each year with the most common lung cancer, stomach cancer, colorectal cancer, liver cancer, and breast cancer. In 2008, approximately 12.7 million cancers were diagnosed and 7.6 million people died of cancer worldwide. This makes cancer the leading cause of death in the developed world, and the second leading cause of death in the developing world (Jemal, 2011). According to National Institute of Cancer, a wing of National Institute of Health in 2016, a rough and ready 1,685,210 new cases of cancer will be identified in the USA and about 395,690 individuals will pass away from the disease. In 2016, the most common cancers are proposed to be bladder cancer, breast cancer, bronchus cancer, colon and rectum cancer, lung cancer, prostate cancer, melanoma of the skin, leukaemia, thyroid cancer, kidney and renal pelvis cancer, pancreatic cancer, and endometrial cancer.

The probability of developing cancer may either increase or decrease depending on what individuals eat and how often they exercise. Nutritional factors are estimated to account for approximately 30 per cent of cancers in industrialized countries, making diet secondary only to tobacco as a hypothetically avoidable cause of cancer. Research to date has revealed few explicit relationships between exact nutritional factors and cancer risk. Studies have investigated the definite role of diet in the progress of major cancers. In developing countries, 60 per cent of these cancers are attributed to a diet low in fruit, vegetables, and animal products. All the way through the world, consumption of thermally very hot drinks and food raises the risk of these cancers.

Alteration in diet possibly will play a significant role in the rising frequency of specific cancers. Conventional and industrial food processing methods as well as microbiological and chemical food contaminants are the factors that may add to the carcinogenicity of diets (Table 1) (Key, 2004).

Table 2 summarizes the association between food or nutrients and cancers, which are frequent or increasing and which have been suggested to be related to dietary habits in the earlier epidemiological studies (Tominaga, 1987).

Demographic details

Earlier it was believed that cancer is more of a developed world issue; however, ratio is changing with time, and at present, 57 per cent of all cancers (excluding non-melanoma skin cancer) occur in less developed countries and 43 per cent in more developed countries. The list for cancer occurrence and mortality is topped by lung cancer in the global population, and it has been the most common cancer since 1985, with 1.35 million cases found in 2002, representative of 12.4 per cent of all new cancers. It is right now one of the most fatal widespread cancers—average 5 year survivals in Europe is approximately 10 per cent, hardly better than (8%–9%) in developing countries and the most avoidable. Globally, in prevalence, stomach cancer ranks fourth; however, owing to its lethality, second among the causes of cancer death. China has the uppermost rates as well as 42 per cent of universal cases. Almost 23 per cent of all cancers among women are breast cancers, the most common cancer among women, with approximately 1.15 million cancer cases in 2002. Prevalence is greatly high in developed countries; more than half of all cases are diagnosed. The most lethal cancer is liver cancer, which is sixth in prevalence worldwide, and ranks third in death, which comes after lung and stomach cancers. The major risk factor for liver cancer is chronic infection with hepatitis B virus (HBV), and hepatitis C virus is as well a factor. Cervical cancer comes after breast cancer, the next most common cancer among women globally, and accounts for 15 per cent of cancer among women. Another more common cancer in developing countries is oesophagus cancer.
Table 1. Diet, nutrition, and cancer: levels of evidence.

| Evidence            | Decreased risk                                                                 | Increased risk                                                                 |
|---------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Convincing          | Physical activity (colon)                                                      | Overweight and obesity (oesophagus, colorectum, breast in post-menopausal women, endometrium, kidney) |
| Probable            | Fruit and vegetables (oral cavity, oesophagus, colorectum)                    | Ataxotoxin (liver)                                                             |
| Possible/insufficient | Fibre, soya, fish, carotenoids  
Vitamin B2, B6, folate, C, D, E  
Calcium, zinc, and selenium  
Non-nutrient plant constituents like flavonoids, isoflavones, lignans | Chinese-style salted fish (nasopharynx)  
Preserved meat (colorectum)  
Salt-preserved food and salt (stomach)  
Very hot drinks and food (oral cavity, pharynx, oesophagus)  
Animal fat  
Heterocyclic amines  
Polycyclic aromatic hydrocarbons  
Nitrosamines |

Table 2. Nutritional risk factors for selected cancers.

| Site for cancer | High risk factors | Low risk factors |
|----------------|-------------------|------------------|
| Stomach        | Salty food  
Salted or dried fish  
Large amount of rice  
Hot drinks and food  
Irregular meals | Milk and dairy products  
Raw vegetables  
Fruit |
| Colorectum     | High-fat diet  
Low-fibre diet  
Beer (rectal cancer)  
Cholesterol | Fibre-rich diet (grains and pulses)  
Good protein–rich diet (cheese, beef) |
| Oesophagus      | Alcoholic beverages  
Hot drinks and food  
Diet poor in protein, vitamins, and minerals | Vegetables and fruit  
Diet rich in good protein, vitamins, and minerals |
| Breast         | High fat/calorie diet  
Cholesterol | –  
Green–yellow vegetables  
Carotene, vitamin A |
| Lung           |                   |                   |

Prevalence of colon as well as rectal cancers varies about 25-fold from the high-income plus high-incidence developed countries to Africa and Asia, where occurrence is smallest. Even though detailed explanations are indefinable, the difference is believed to be ecological, with the leading factors related to most important dietary components. Prostate cancer is comparatively common, more so in industrialized countries than in developing countries, 19 versus 5.3 per cent. Three-quarters of all prostate cancer cases are in men aged 65 and older (Institute of Medicine, 2007).

Role of nutritional factors in pathogenesis of cancer

Cancer of oral cavity and pharynx

Several studies confirmed dietary patterns particularly; food-intake patterns have a pertinent role in the possibility of oral as well as pharyngeal cancer. The oral cancer risk appeared to be reduced by about 50 per cent by the addition of one serving of fruit and vegetables per day, protection by fruit and vegetables mainly because of selected micronutrients, counting β-carotene, and other carotenoids (La Vecchia et al., 1991; Zheng et al., 1993). However, pre-cancerous lesions of the oral cavity induce alterations in food practices (e.g. lessened citrus as well as fruit consumption), which will so be the consequence, more willingly than the cause, of the disease. In US study, moreover, we found some direct linkage among meat, saturated fats, cholesterol intake, and risk of oral cancer, and from the study conducted in Northern Italy (La Vecchia et al., 1991), a linkage was found with retinol, an indicator of meat intake. Direct associations were found with eggs, pork, and sausages, which may again imitate a hostile effect of cholesterol and animal fats (Franceschi et al., 1991; Marshall and Boyle, 1996) and probably of carcinogens in broiled meat (de Meester and Gerber, 1993) but also will possibly be a common sign of a poorer diet. As in earlier studies (Marshall et al., 1992; Marshall and Boyle, 1996), a small indication emerged for a link among bread and cereals and oral cancer. The nutritional epidemiology of oral cancer is also marked by two risk factors that appear far more powerful than nutrition: tobacco use and alcohol consumption (Marshall et al., 1992). Overall, a high intake of fruit and vegetables probably reduces the risk of oral cancer, and consumption of very hot drinks and food, typically consumed in some cultures, probably increases the risk of cancers of the oral cavity and pharynx.

Gastrointestinal cancer

Gastrointestinal (GI) cancer refers to malignant conditions of the GI tract and accessory organs of digestion, including the oesophagus, stomach, pancreas, small intestine, rectum, and anus. Oesophageal cancer is among upper digestive tract cancers and mainly prevalent in developing and underdeveloped countries. There is much sufficient evidence which supports that the use of uncooked fruit and vegetables probably reduces the risk of oral cancer, and consumption of very hot drinks and food, typically consumed in some cultures, probably increases the risk of cancers of the oral cavity and pharynx.

Prevalence of colon as well as rectal cancers varies about 25-fold from the high-income plus high-incidence developed countries to Africa and Asia, where occurrence is smallest. Even though detailed explanations are indefinable, the difference is believed to be ecological, with the leading factors related to most important dietary components. Prostate cancer is comparatively common, more so in industrialized countries than in developing countries, 19 versus 5.3 per cent. Three-quarters of all prostate cancer cases are in men aged 65 and older (Institute of Medicine, 2007).
cells in opposition to attack by carcinogens, and oesophageal epithelial cells are more susceptible to the deficiency in vitamin A (Poulain et al., 2009). Some studies have provided sturdy confirmation that polyphenol derived from tea may possibly possess the bioactivity to have an effect on the development of different cancers (Khan and Mukhtar, 2007). Also the relationship between drinking different tea and their associated danger has been reported in some studies from diverse parts of the world (Castellsague et al., 2000; Ganesh et al., 2009; Ibiebele et al., 2010; Li et al., 2002). Among minerals, the anti-cancer role of selenium and zinc was the research focus, and some researchers reported that selenium and zinc were preventive factors for occurrence of oesophageal cancer (Cai et al., 2006; Lu et al., 2006; Wei et al., 2004).

Evidence supports that gastric cancer has an environmental etiology, of which diet appears to be the most important component. Furthermore, a human model of gastric carcinogenesis has been developed and studied extensively based on a multistage process in which dietary constituents act on the mucosa at various stages, leading from superficial gastritis to carcinoma, and the role of N-nitroso compounds has been emphasized (Correa et al., 1988).

A case–control study conducted in Spain suggests that higher intake of salt and smoked as well as pickled food may perhaps be linked with a higher danger of gastric cancer, and this relationship will possibly result in the intragastric formation of nitrosamines (Ramón et al., 1993). Salt is not a directly acting carcinogen, although it is thought to raise the risk of gastric cancer all the way through direct damage to gastric mucosa, resulting in gastritis, increased deoxyribonucleic acid (DNA) synthesis, along with cell proliferation (World Cancer Research Fund 1997). Superficial gastritis can lead to chronic atrophic gastritis, which is considered to be a precursor lesion in the progress of gastric cancer (Nomura et al., 1996). Frequent consumption of beans and vegetables is reciprocally associated with risk of gastric cancer, and fresh meats, dairy products, and fresh fish are positively associated with risk of gastric cancer, whereas frequent consumption of sweets was associated with 70 per cent increased risk of gastric cancer (Ward et al., 1999). A diet rich in meat-derived food has been suggested to play a role in gastric carcinogenesis by several studies in Western populations (Buiatti et al., 1989; Wu-Williams et al., 1990; De Stefani et al., 1998). The underlying mechanism for this association is unclear but may involve increased tolerance to DNA damage associated with reduced mismatch repair (MMR) genes activity (Buermeyer et al., 1999).

Cancer of the exocrine pancreas ranks fourth for cancer mortality in US men and women and is among the most rapidly fatal cancers worldwide (Surveillance, Epidemiology, and End Results Program, 1997). Thirty to fifty per cent of pancreatic cancers may be attributed to dietary factors (World Cancer Research Fund in association with the American Institute of Cancer Research, 1997). Dietary factors influence pancreatic cancer progression, which involves nutritional components affecting insulin insensitivity or else insulin-resistance pathways. Pancreatic exocrine cells are exposed to very high insulin concentrations, and facts indicate that insulin acts as a growth promoter and mutagen in the pancreas resulting in pancreatic tumour promotion. In response to high blood glucose concentrations, insulin is secreted into the blood, and the pancreas is exposed to a great deal of higher insulin concentrations; comparable to blood cancer risk, pancreatic cancer risk might increase as a result of nutritional factors that generate insulin spikes (Fish et al., 1996; Kazakoff et al., 1996; Zagorsky et al., 2005). A second main hypothesis linking dietary intake with pancreatic cancer suggests that dietary nutrients like β-carotene and total carotenoids, high serum α-tocopherol concentration, or vitamin C that reduce DNA damage or mutations by reducing oxidative stress and inflammation have inversely been associated with risk of pancreatic cancer (Lin et al., 2005; Chan et al., 2005; Stolzenberg-Solomon et al., 2009). The defensive effect of nutrients linked with fruit and vegetables is also found, as the ingestion of most nutrients points out a dose-dependent risk reduction of pancreatic cancer growth. Antioxidants levels in serum have positively been associated with intake of fruit and vegetables, (Dauchet et al., 2008), and these food items have been contrariwise related to pancreatic cancer risk (Inoue et al., 2003; Nkondjock et al., 2008). Non-enzymatic nutritional antioxidants (e.g. vitamin C and selenium) work jointly with enzymatic mechanisms to provide protection against oxidative stress (Maritim et al., 2003). Various other nutritional factors like meat, dairy products, and eggs have also been investigated and encountered with elevated disease risks in some studies, although some studies reported null results (Mills et al., 1988; Coughlin et al., 2000; Stolzenberg-Solomon et al., 2002; Michaud et al., 2003). Increased risk has generally been attributed to the fat, saturated fat, or cholesterol content of meats and other animal products (Ghadirian et al., 2003; Risch et al., 2003; Vimalachandrar et al., 2004; Food, nutrition and the prevention of cancer, 1997). Alternatively, meat preparation methods, such as grilling and frying, have been proposed as a source of carcinogens (World Cancer Research Fund 1997; Ghadirian et al., 2003; Li et al., 2004). Small intestine cancer is reasonably uncommon. Tobacco and alcohol consumption was unrelated to small intestine cancer risk; however, weekly or repeated consumption of red meat and monthly or more recurrent intake of salted or smoked food were related to 2- to 3-fold increases in risk. Nutritional factors are possibly concerned about the risk of small intestine cancer, although further research in other settings is requisite to make clear the determinants of these uncommon cancers (Chow et al., 1993).

Colorectal cancer is a leading cause of death in the Western world. It is multifactorial in origin, combining genetic and environmental causes. Certain lifestyle factors, including nutrition, have been associated with a higher cancer risk. Newmark et al. (1984) studied the effect of dietary fat, phosphate, and calcium in colon cancer and suggested that increased dietary fat will endorse colon cancer by raising the free ionized fatty acid levels and bile acids in the colon contents. The annoying and toxic effects of the free acids in the presence of calcium ions on colon epithelial cells can be reduced by being converted to insoluble calcium soaps. Supplementary dietary calcium level to provide sufficient calcium and therefore to decrease the possible toxicity of dietary fat was considered (Newmark et al., 1984). High consumption of vegetables and fruit and the avoidance of highly refined sugar containing food are likely to reduce the risk of colon cancer, although the responsible constituents remain unclear (Giovannucci et al., 1994). An alternative hypothesis proposed by Giovannucci (1995) is that hyperinsulinaemia promotes colon carcinogenesis. For colonic epithelial cells, insulin is an essential growth factor and is a mitogen of in vitro tumour cell development. The insulin/colon cancer theory is basically indirect and depends on the resemblance of factors which generate high insulin levels with those related to colon cancer risk supported by epidemiological study. The major determinants of insulin resistance and hyperinsulinaemia are obesity, physical inactivity, and maybe a low dietary polyunsaturated fat-to-saturated fat ratio and come into view related to colon cancer risk. In the distal colon, elevated consumption of red meat raises the risk of colon cancer. Beef, pork, or lamb as a main dish is the particular food item most sturdily correlated with higher risk of colon cancer or adenoma. In the small intestine, fat from red meat may well be less
that dairy products were not significantly associated with lung cancer. However, some studies are in contradicted farmer studies and found supplements owing to the exposure of heat and it turns into pro-
ition and lung cancer risk, and produced inconsistent results. Few trial cannot rule out, then the dosage, duration of use, method of
duction in Missouri focused on non-smoking women with lung cancer, 
ment was appreciably decreased by photoprotective effect observed in the combination of carotenoids and α-tocopherol (Stahl et al., 2000). In a similar study, β-carotene supplementation or mixture of carotenoids daily for 12 weeks was shown together to have photoprotective effects by reducing erythema induced by UV in human skin and gives defence against exposure to UV radiation (Heinrich et al., 2003). Carotenoids may slow down skin carcinogenesis due to their antioxidant abilities; β-carotene improves immune system functioning, whereas provitamin A carotenoids could stop skin cancer through its conversion to retinoids (McNaughton et al., 2005). Conversely, there are a few concerns in relation to the safety of enormously high doses of carotenoid supplementation, owing to higher lung cancer occurrence and mortality among smokers taking supplemental β-carotene (Omenn et al., 1996). Numerous epidemiological studies have suggested that extreme use of red meat such as beef, pork, and lamb, and processed meats including bacon, sausage, and hot dogs is connected with higher rate of cancer and danger of all-cause mortality. Some carcinogens present in meat, which may increase the risk of cancer, comprise heterocyclic amines, polycyclic aromatic hydrocarbons, and nitrates as well as nitrates (used as preservatives) (Kushi et al., 2012). A diet rich in high fat influences DNA damage, decreased cell apoptosis, increased inflammatory cytokines in the skin, and oxidative stress, and it also enhances skin carcinogenesis influencing the composition of cell membrane lipids and intercellular communication. A high-fat diet and high intake of red meat as well as processed meats are connected with skin cancer (McNaughton et al., 2005).

**Skin cancer and diet**

In USA, skin cancer is the most common form of cancer which affects nearly one in five Americans (Skin cancer facts, 2014). In current years, skin cancer has been diagnosed greater than all other types of cancers combined, including basal cell carcinoma (BCC), squamous cell carcinoma (SCC), along with cancer of melanocytes (Siegel et al., 2012; Actinic keratosis, 2014; Skin cancer facts, 2014). For skin cancer, there are numerous entrenched risk factors and a dietary factor is one of them. Evidence also supported that nutritional interventions may well benefit people who are at high risk of skin carcinoma. Researchers prove that people who consumed higher levels of fruit and vegetables had a 54 per cent reduced risk of SCC (Ibiebele et al., 2007). Reduction in the risk was related to consumption of green leafy vegetables. Reduced risk of melanoma has been observed with high intake of vitamins A, C, D, α- and β-carotene, cryptoxanthin, lutein, and lycopene compared with low intake (Mullen et al., 2004). Regular eating (more than three servings per week) of celeriac and pomegranates was linked with a considerably reduced risk of BCC and SCC (de Vries et al., 2012). Abundant nutrients like vitamins C and E are present in plants acting as antioxidants and so may possibly help us to guard against skin cancer. Vitamin C acts by scavenging free radicals to restore the activity of other antioxidants, resulting in enhancement of the immune system, and hydroxylates lyseine as well as proline in the synthesis of connective tissues proteins, which may modify tumour development. An intracellular antioxidant vitamin E prevents lipid peroxidation (McNaughton et al., 2005). The variant of vitamin A, retinoic acid, is important in skin cell proliferation, differentiation, and maintenance and will possibly lessen the quantity of ultraviolet (UV) light reaching the underlying layers of the skin by raising epidermal thickness with the intention that taking carotenoid through food has been shown to reduce the danger of skin cancer (Siegel et al., 2012). Researchers established that UV light-induced erythema was appreciably decreased by photoprotective effect observed in the combination of carotenoids and α-tocopherol (Stahl et al., 2000). An intracellular antioxidant vitamin E prevents lipid peroxidation (McNaughton et al., 2005). The variant of vitamin A, retinoic acid, is important in skin cell proliferation, differentiation, and maintenance and will possibly lessen the quantity of ultraviolet (UV) light reaching the underlying layers of the skin by raising epidermal thickness with the intention that taking carotenoid through food has been shown to reduce the danger of skin cancer (Siegel et al., 2012). Researchers established that UV light-induced erythema was appreciably decreased by photoprotective effect observed in the combination of carotenoids and α-tocopherol (Stahl et al., 2000). In a similar study, β-carotene supplementation or mixture of carotenoids daily for 12 weeks was shown together to have photoprotective effects by reducing erythema induced by UV in human skin and gives defence against exposure to UV radiation (Heinrich et al., 2003). Carotenoids may slow down skin carcinogenesis due to their antioxidant abilities; β-carotene improves immune system functioning, whereas provitamin A carotenoids could stop skin cancer through its conversion to retinoids (McNaughton et al., 2005). Conversely, there are a few concerns in relation to the safety of enormously high doses of carotenoid supplementation, owing to higher lung cancer occurrence and mortality among smokers taking supplemental β-carotene (Omenn et al., 1996). Numerous epidemiological studies have suggested that extreme use of red meat such as beef, pork, and lamb, and processed meats including bacon, sausage, and hot dogs is connected with higher rate of cancer and danger of all-cause mortality. Some carcinogens present in meat, which may increase the risk of cancer, comprise heterocyclic amines, polycyclic aromatic hydrocarbons, and nitrates as well as nitrates (used as preservatives) (Kushi et al., 2012). A diet rich in high fat influences DNA damage, decreased cell apoptosis, increased inflammatory cytokines in the skin, and oxidative stress, and it also enhances skin carcinogenesis influencing the composition of cell membrane lipids and intercellular communication. A high-fat diet and high intake of red meat as well as processed meats are connected with skin cancer (McNaughton et al., 2005).

**Breast cancer**

Breast cancer is one of the most common cancers and the leading cause of cancer death among females, accounting for 23 per cent of all cancer cases and 14 per cent of the cancer deaths all over the world (Ferlay et al., 2010). However, breast tumours may differ

**Cancer of respiratory organs**

There are few observational studies of diet and lung cancer which suggest that increased intake of vegetables and fruit is associated with reduced risk in men and women; in various countries; in smokers, ex-smokers, and never-smokers; and for all histological types of lung cancer.

Slight protective effects were suggested for cruciferous vegetables and tomatoes, in addition to the strong protection afforded by carrot consumption. Prospective studies of blood β-carotene levels, debatably the best obtainable biomarker of vegetable and fruit intake, point out that low β-carotene level is prognostic of increased lung cancer prevalence. Although, in a randomized and placebo-controlled clinical trial in male smokers, lung cancer occurrence and total mortal-
tunity were raised considerably among the men receiving β-carotene supplements owing to the exposure of heat and it turns into pro-
carcinogen. If β-carotene can prevent lung carcinogenesis, which the trial cannot rule out, then the dosage, duration of use, method of administration, and/or subpopulation are critical. Several epidemiological studies have studied the relationship between daily consumption and lung cancer risk, and produced inconsistent results. Few studies have been reported that intake of diary product may increase the risk of lung cancer (Axelsson et al., 1996; Nyberg et al., 1998). However, some studies are in contradicted farmer studies and found that dairy products were not significantly associated with lung cancer risk (Rachtan et al., 2002; Van der Pols et al., 2007). One study conducted in Missouri focused on non-smoking women with lung cancer, including a large number with adenocarcinoma, showed a strongly increasing trend in lung cancer risk with increased saturated fat consumption that may have been masked in earlier studies of lung cancer involving a high percentage of smokers (Michael et al., 1993). Several observational epidemiological studies have indicated that diets high in fat, saturated fat, and cholesterol may increase the risk of lung cancer. The results showed a significant positive association between dietary cholesterol and the risk of lung cancer in men and women (Goodman et al., 1988). A positive dose–response relation has been observed between the consumption of processed meats, dairy foods, eggs, and particular desserts, and the risk of lung cancer in men. Researchers also found a positive trend in the lung cancer risk in women with higher intake of some processed meats like bacon, spam, and desserts such as cakes and custard or cream pies. The dose–response association tended to be stronger among men who were intense smokers and also who were identified with squamous cell cancer of the lung (Goodman et al., 1992). However, some data were inconsistent and concluded that there is no significant association between lung cancer and dietary cholesterol or saturated fat (Veierod et al., 1997).
clinically and biologically by hormone receptor status and menopausal status. Dietary factors have long been thought to play a major role in the development of breast cancer; it stands out among the modifiable risk factors and has thus been investigated in numerous studies mostly with a focus on specific nutrients or components. Vegetables and fruit intake has been hypothesized to decrease breast cancer risk. Studies have been inconsistent. A case–control study which examined the relationship between diet, particularly vegetables and fruit, and breast cancer concluded that intake of vegetables shows a reduced risk of premenopausal breast. Evaluated components found collectively in vegetables can have a synergistic effect on the risk of breast cancer (Freudenheim et al., 1996). A meta-analysis was carried out, in order to summarize published data on the relationship between breast cancer, fruit and vegetable consumption and/or the intake of beta-carotene and vitamin C. This analysis confirms the association between intake of vegetables and, to a lesser extent, fruits and breast cancer risk from published sources. Increasing vegetable consumption might reduce the risk of breast cancer (Gandini, 2000). In a case–control study of diet and breast cancer estimated by menopausal status, it was observed that a significant reduction in breast cancer risk is associated with higher dietary intake of total lignan precursors, at least among premenopausal women (McCann, 2004). Another case–control study carried out in Uruguay evaluated the protective effect associated with vegetables and fruit on nutrients and bioactive substances present in plant food in breast cancer cases. The results related to vegetable and nutrient intake were consistent with antioxidant and antiestrogenic effects. This may be arbitrated, among other nutrients, by intake of dietary fibre and lycopene (Ronco et al., 1999). An analytical study has been accomplished to assess and measure the effect of eating of olive oil, margarine, and a variety of food groups on the breast cancer risk. Majority of macronutrients are not showing noteworthy relations with breast cancer risk, although vegetables and fruit are contrariwise, considerably, and strongly associated with this risk. Evidence also supported that ingestion of olive oil decreases the risk of breast cancer, whereas margarine ingestion shows to be related to high risk for the disease (Trichopoulou et al., 1995). A Chinese study was conducted to examine the association between vegetables and fruit intake and breast cancer risk, which encountered an inverse association between the consumption of vegetable, fruit, and antioxidant nutrients and breast cancer risk and depicted a protective role of vegetables and fruit in breast cancer (Zhang et al., 2009). Furthermore, few data are inconsistent and did not significantly correlate nutritional factors with breast cancer. A pooled analysis of cohort studies suggested that consumption of fruit and vegetables during adulthood or pre-menopausal state is not significantly associated with breast cancer risk and did not identify any fruit and vegetable subgroup or specific fruit or vegetable that had stronger and statistically significant associations with breast cancer risk compared with the associations observed for total consumption of fruit and vegetables (Smith-Warner, 2001). In a randomized trial of 7.3 year follow-up period of a nutritional intervention with which to attain a considerable change of diet that is rich in vegetables, fruit, and fibre and low in fat, the risk of developing further breast cancer events and survival was not changed in women treated earlier for early stage disease. In repetition, no major benefit was observed, in general, among population subgroups characterized by demographic characteristics, baseline diet, or initial tumour types (Pierce et al., 2007). A prospective multicentre study on dietary questionnaire carried out between the ages of 25 and 70 years including both pre- and post-menopausal women observed no association of risk with either total consumption of vegetables and fruit or with vegetable subgroups (Van Gils et al., 2005). In a population of fairly young, pre-menopausal women, ingestion of red meat was linked with an elevated risk of hormone receptor–positive breast cancer but not with hormone receptor–negative cancer risk (Cho et al., 2006). A meta-analysis of 31 case–control and cohort studies establishes a 17 per cent increase in risk related to the highest category of meat intake (Boyd et al., 2003). On the other hand, a pooled study of the raw data from eight potential cohort studies conducted in North America, Canada, and Western Europe was not capable to reveal such association (Mossmer et al., 2002). A case–control analysis of Chinese women in Shanghai establishes that the optimistic association with red meat ingestion was mainly limited to those who used deep-frying cooking methods, predominantly between those who deep-fried food to the “well done” stage, in pan drippings and in meat surfaces that show a brown or black crust (Dai et al., 2002), suggestive of an effect of heterocyclic amines or other carcinogens produced at high temperatures. Nonetheless, the Nurses’ Health nested case–control analysis showed no increase in risk with cooking method or meat eating even for the use of charred meat more than once in a week in rapid acetylators (Gertig et al., 1999).

Cervical cancer

Globally, in women, cervical cancer is the second most frequent cancer between the age of 15 and 44 years and most general in developing countries (Parkin et al., 2001). Human papillomaviruses (HPV) make up to 83 per cent of all cervical cancer cases and recognized as an essential but not as an enough cause for cervical cancer. The risk of developing cervical cancer in combination with HPV may influence endogenous as well as exogenous co-factors (Bosch et al., 2002; Castellsague et al., 2003; Munoz et al., 2004). Some dietary factors could be involved as co-factors in cervical carcinogenesis, but evidence is inconclusive. Only a small number of case–control and cohort studies looked at the role of diet intake as a cofactor for cervical cancer or as a risk factor for HPV persistence (Garci’a-Closas et al., 2005; World Cancer Research Fund and American Investigation of Cancer Research, 2007). In a recent comprehensive review, an international expert committee concluded that there is limited evidence suggesting that carrot intake may protect against cervical cancer (World Cancer Research Fund and American Investigation of Cancer Research, 2007).

Prostate cancer

Incidence and mortality rates vary widely across populations, with the highest rates in North America and Northern Europe, intermediate rates in Southern Europe and Latin America, and the lowest rates in Asia and Africa. Higher ingestion of animal protein may increase the occurrence of prostate cancer by enhancing growth hormone activity (Sato, 1963). Ecological studies suggested that milk drinking is strongly linked with both occurrence and mortality from prostate cancer (Gannaa et al., 2002; Colli and Colli, 2006). Evidence also suggests that a higher intake of dairy protein might increase the risk of prostate cancer by increasing the production of insulin-like growth-factor-I (IGF-I), which can consecutively endorse the progress of prostate cancer (Allen et al., 2007). It has been hypothesized that higher intake of calcium, mainly from dairy products, may possibly increase the risk by suppressing the synthesis of 1,25-dihydroxyvitamin D, which has an anti-tumour effect on human prostatic cells in vitro (Giovannucci, 1998). Most mysteriously, many meats are cooked at elevated temperatures, for instance, by pan frying, grilling, or barbecuing resulting in the
formation of heterocyclic amines, a potent carcinogen in animals (Sugimura et al., 2000). On the other hand, green vegetables demonstrated a defensive role in violent prostate cancer. An inverse relationship with green–yellow vegetables has been observed in the study conducted in Japan (Ohno, 1988); one more study conducted in Canada established an inverse relationship with green vegetables, cruciferous vegetables, and tomatoes (Jain, 1999); a study conducted in the USA reported a converse association with carrots (Schuman, 1982); and an inverse association with carrots, cabbage, and spinach was found in the study conducted in South Africa (Walker, 1992).

Conclusion
The etiology and pathogenesis of cancer is a multifaceted interplay mechanism of genetic and environmental factors. Nutritional intake and nutrient supplements are considered to be important environmental factors, so scientists have reported that dietary and nutrients might play a significant role in cancer development. In addition, many studies have reported the close link of the quantity and quality of dietary nutrients with cancer occurrence and pathogenesis. There is a noticeable difference in cancer development with the similar dietary intake among individuals. This could be explained by the dissimilarity in their genetic polymorphisms, which leads to materializing the concept of nutrigenomics and nutrigenetics which may explain the association of specific nutrient intake with genetic variations on cancer pathogenesis.

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