RESEARCH ARTICLE

Folate-Related Nutrients, Genetic Polymorphisms, and Colorectal Cancer Risk: the Fukuoka Colorectal Cancer Study

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Abstract

One-carbon metabolism plays an important role in colorectal carcinogenesis. Meta-analyses have suggested protective associations of folate and vitamin B6 intakes with colorectal cancer primarily based on studies in Caucasians, and genetic polymorphisms pertaining to the folate metabolism have been a matter of interest. Less investigated are the roles of methionine synthase (MTR) and thymidylate synthetase (TS) polymorphisms in colorectal carcinogenesis. In a study of 816 cases and 815 community controls in Japan, we investigated associations of dietary intakes of folate, methionine, vitamin B6, vitamin B12, and vitamin B9, with colorectal cancer risk. The associations with MTR 2756A>G, MTRR 66A>G, and TSER repeat polymorphism were examined in 685 cases and 778 controls. Methionine and vitamin B6 intakes were inversely associated with colorectal cancer risk, but the associations were totally confounded by dietary calcium and n-3 fatty acids. The other nutrients showed no association with the risk even without adjustment for calcium and n-3 fatty acids. The TSER 2R allele was dose-dependently associated with an increased risk. The MTR and MTRR polymorphisms were unrelated to colorectal cancer risk. There was no measurable gene-gene or gene-nutrient interaction, but increased risk associated with the TSER 2R allele seemed to be confined to individuals with high folate status. This study does not support protective associations for folate and vitamin B6. The TSER 2R allele may confer an increased risk of colorectal cancer. The role of the TSER polymorphism in colorectal carcinogenesis may differ by ethnicity.

Keywords: Colorectal cancer - methionine synthase - thymidylate synthase - B-vitamins - case-control study

Introduction

The one-carbon metabolism has drawn considerable attention in relation to colorectal carcinogenesis (Ulrich, 2005; Hubner and Houlston, 2009; Williams, 2012). A folate metabolite, 5-methyl tetrahydrofolate (THF), provides the methyl group in the reaction by methionine synthase (MTR) to convert homocysteine to methionine, the precursor of S-adenosylmethionine (SAM). The SAM is the universal methyl-group donor for methylation of a wide variety of biological substrates. Thus folate/methionine depletion results in aberrant DNA methylation, i.e., global genomic hypomethylation and specific methylation of CpG clusters in the promoters of tumor suppressor and DNA repair genes. Methylenetetrahydrofolate reductase (MTHFR) irreversibly converts 5, 10-methylene THF to 5-methyl THF. The substrate of MTHFR is required for conversion of deoxyuridylate to thymidylate by thymidylate synthase (TS). Depletion of the thymidylate pool results in uracil misincorporation into DNA, leading to single and double strand breaks (reviewed in Ulrich, 2005; Hubner and Houlston, 2009). Vitamin B6 (riboflavin), vitamin B12 (pyridoxine), and vitamin B12 (cobalamin) are involved in the key reactions in one-carbon metabolism (Ulrich, 2005). Vitamin B6 is the precursor for a cofactor of MTHFR. Vitamin B12 is not only a cofactor for cystathionin beta-synthase (CBS) to convert homocysteine to cystathionine but also is required in the conversion of serine to glycine, recycling THF (derivative of 5-methyl THF after methyl-transfer to homocysteine) to 5, 10-methylene THF. Vitamin B12 is a coenzyme of MTR. MTR reductase (MTRR) catalyzes the reduction of

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oxidized vitamin B<sub>12</sub>, releasing an activated vitamin B<sub>12</sub> and MTR. Alcohol is also known to play an important role in folate metabolism, being a folate antagonist and an inhibitor of MTR (Mason and Choi, 2005).

High folate intake has been related to decreased risk of colorectal cancer (Sanjoaquin et al., 2005; Kim et al., 2010; Kennedy et al., 2011) in a series of meta-analyses and also in recent cohort (Stevens et al., 2011) and case-control (Kim et al., 2012) studies, whereas several studies have failed to find a protective association between dietary folate and colorectal cancer risk in Asia (Ishihara et al., 2007; Shrubsole et al., 2009) and Europe (VanGuelpen et al., 2006; Eussen et al., 2010). While low methionine intake, especially in combination with low folate and high alcohol intake, was related to an increased risk of colorectal cancer (Giovannucci et al., 1995; Razzak et al., 2012), methionine intake was unrelated to colorectal cancer in other studies (Harnack et al., 2002; Le Marchand et al., 2002; Ishihara et al., 2007; Murtaugh et al., 2007; Shrubsole et al., 2009). Vitamin B<sub>6</sub> and B<sub>12</sub> have been unrelated to colorectal cancer risk in many studies of different populations (Harnack et al., 2002; Le Marchand et al., 2002; 2009; Ishihara et al., 2007; Murtaugh et al., 2007; Sharp et al., 2008; Weinstein et al., 2008; Shrubsole et al., 2009), while recent studies showed a protective association with plasma vitamin B<sub>6</sub> (Eussen et al., 2010) and with dietary vitamin B<sub>6</sub> (Zschäbitz et al., 2013). The two latter studies found no association with plasma or dietary vitamin B<sub>12</sub>. On the other hand, dietary intake and plasma levels of vitamin B<sub>6</sub> have fairly consistently been related to decreased risk of colorectal cancer, as noted in two meta-analyses (Theodoratou et al., 2008; Larsson et al., 2010). Of the two recent large prospective studies in the United States, one reported a protective association between dietary intake of vitamin B<sub>6</sub> and colorectal cancer (Zschäbitz et al., 2013) while the other failed to corroborate such an association (Zhang et al., 2012).

Functional genetic polymorphisms of the key enzymes in the folate metabolism have also been a matter of interest in colorectal carcinogenesis (Sharp and Little, 2004). Two functional polymorphisms are known for MTHFR (677C>T and 1298A>C), and the variant alleles, particularly of the former, are associated with lower enzyme activities (Sharp and Little, 2004). A decreased risk of colorectal cancer in different populations (Harnack et al., 2002; Le Marchand et al., 2002; Ishihara et al., 2007; Murtaugh et al., 2007; Sharp et al., 2008; Weinstein et al., 2008; Shrubsole et al., 2009), while recent studies showed a protective association with plasma vitamin B<sub>6</sub> (Eussen et al., 2010) and with dietary vitamin B<sub>6</sub> (Zschäbitz et al., 2013). The two latter studies found no association with plasma or dietary vitamin B<sub>12</sub>. On the other hand, dietary intake and plasma levels of vitamin B<sub>6</sub> have fairly consistently been related to decreased risk of colorectal cancer, as noted in two meta-analyses (Theodoratou et al., 2008; Larsson et al., 2010). Of the two recent large prospective studies in the United States, one reported a protective association between dietary intake of vitamin B<sub>6</sub> and colorectal cancer (Zschäbitz et al., 2013) while the other failed to corroborate such an association (Zhang et al., 2012).

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We investigated associations of folate, methionine, vitamin B<sub>6</sub>, vitamin B<sub>12</sub> and vitamin B<sub>12</sub>, as well as of the MTR, MTRR, and TS polymorphisms, with colorectal cancer risk and effect modification of these nutrients on the association with the genetic polymorphisms including MTHFR 677C>T and 1298A>C in a community-based case-control study in Japan. We previously examined the relation of the two MTHFR polymorphisms to colorectal cancer and reported a decreased risk associated with the MTHFR 677TT genotype, particularly among those with no alcohol consumption (Yin et al., 2004).

Materials and Methods

The Fukuoka Colorectal Cancer Study is a case-control study to investigate the relation of lifestyle factors and genetic susceptibility to colorectal cancer risk in Fukuoka City and three adjacent areas, Japan. The study protocol was approved by the ethics committees of the Kyushu University Faculty of Medical Sciences and the participating hospitals. Details of the methods have been reported elsewhere (Kono et al., 2004), and methodological issues relevant to the present analysis are described below.

Subjects

Cases comprised a consecutive series of patients with histologically confirmed incident colorectal adenocarcinomas who were admitted to two university hospitals or six affiliated hospitals for surgical treatment during the period from September 2000 to December 2003. Eligible cases were aged 20-74 years at the time of diagnosis, lived in the study area, had no prior history of partial or total removal of the colorectum, familial adenomatous polyposis or inflammatory bowel disease, and were mentally competent to give informed consent and to complete the interview. Of the 1,053 eligible cases, 840 cases (80%) participated in the interview, and 685 gave informed consent for the genotyping.

Eligibility criteria for controls were the same as described for the cases except that they had no prior diagnosis of colorectal cancer. A total of 1,500 persons living in 15 small areas were selected as control candidates by a two-stage random sampling, and were invited to participate in the study by mail. Of these, 833 persons participated in the survey, and 778 gave informed consent for genotyping. The net participation rate for the interview was 60% (833/1382), with 118 persons excluded in the denominator for the following reasons: death (n=7), migration from the study area (n=22), undelivered mail (n=44), mental incompetence (n=19), history of partial or...
total removal of the colorectum (n=21), and diagnosis of colorectal cancer after the survey (n=5). In the analysis on nutrients, we excluded individuals in the highest and lowest 1% of energy intake among the cases and controls combined with stratification by sex and age class (<55, 55-64, and ≥65 years) to remove those whose diet was inadequately captured by the dietary assessment. Thus 816 cases and 815 controls remained in the analysis on nutrients. Associations with the genetic polymorphisms were examined in all of the subjects who had given consent to genotyping (685 cases and 778 controls).

**Interview**

Research nurses interviewed cases and controls in person regarding smoking, alcohol use, physical activity, and other factors using a standardized questionnaire. Reference dates for the questionnaire were the date of onset of symptoms or screening for cases and at the time of interview for controls. Anthropometric questions inquired about height (cm), current body weight (kg), and body weight 10 years earlier. Body mass index (kg/m²) 10 years earlier was used here, because the current body mass index was unrelated to risk (Isozumi et al., 2006). Habitual alcohol consumption 5 years prior to the reference date was ascertained. The daily amount of alcohol was expressed using the conventional Japanese units; one go (180mL) of sake, one large bottle (633mL) of beer, and half a go (90mL) of shochu were each expressed as one unit; and one drink (30mL) of whisky or brandy and one glass (100mL) of wine were each converted to a half unit. The reported alcohol intake was highly reproducible (Spearman r=0.82), as tested on 29 control subjects with an interval of approximately one year.

With regard to smoking, ever-smokers were asked about duration of smoking in years and numbers of cigarettes smoked per day for each decade of life from the second to the last decade. We calculated the cumulative exposure to cigarette smoking until the beginning of the previous decade of age. Questions on physical activities elicited type of job and leisure-time activities 5 years before (Isozumi et al., 2006), and the latter was expressed as a sum of metabolic equivalents (MET) multiplied by hours of weekly participation in each activity, i.e., MET-hours per week. Vitamin use was also ascertained in the interview, but the amount was not quantified.

**Dietary assessment**

Consumption frequencies and portion sizes of 148 food/beverage items were ascertained by a computer-assisted interview, and quantitative intake estimates were obtained for selected nutrients and food groups (Uchida et al., 2007). Individuals were asked to report their usual consumption over one year prior to the reference date. In a validation study in 28 controls, who recorded their diets over 7 days each in 4 consecutive seasons, the dietary interview was repeated with an interval of one year. Pearson correlation coefficients of energy-adjusted intakes between the first interview (and the second interview in parentheses) and diet record were as follows: folate 0.48 (0.55), methionine 0.36 (0.45), vitamin B₆ 0.57 (0.49), vitamin B₁₂ 0.61 (0.56), and vitamin B₁₂ 0.13 (0.48).

Genotyping

DNA was extracted from the buffy coat using a commercial kit (Qiagen, Hilden, Germany). Both MTR 2756A>G (rs1805087) and MTRR 66A>G (rs1801394) polymorphisms were determined by the PCR-RFLP method using the primers described elsewhere (Le Marchand et al., 2002). Restriction enzyme HaeIII was applied to the 189-bp PCR product for the MTR 2756A>G polymorphism, and the digestion resulted in 159-bp and 30-bp fragments the 2756G allele. The MTRR 66A>G genotype was determined by digestion with AflIII, which cleaves the 192-bp PCR product for the 66G allele into 161-bp and 31-bp fragments. Genotypes of the TSER 28-bp repeat polymorphism were determined by the method described previously (Ulrich et al., 2002).

**Statistical analysis**

Associations of the nutrients and genetic polymorphisms with colorectal cancer risk were examined in terms of odds ratio (OR) and 95% confidence interval (CI), which were obtained from logistic regression analysis. Statistical adjustment was made for sex, 5-year age class (the lowest class of <45 years), residency area (Fukuoka City or the adjacent areas), body mass index 10 years before (<22.5, 22.5-24.9, 25.0-27.4, or ≥27.5 kg/m²), smoking (0, 1-399, 400-799, or ≥800 cigarettes/years), alcohol intake (0, 0.1-0.9, 1.0-1.9, or ≥2.0 units/day), type of job (sedentary or non-sedentary), leisure-time physical activity (0, 1-15.9, or ≥16 MET-hours/week), and parental history of colorectal cancer. In the analysis on nutrients, further adjustment was made for dietary intakes of calcium and n-3 polyunsaturated fatty acids (PUFA), which were associated with decreased risk of colorectal cancer in the present study population (Kimura et al., 2007; Mizoue et al., 2008). Nutrient intake was adjusted to 2,000 kcal/day by the regression residual method (Willett and Stampfer, 1986). Trends in the OR were evaluated with ordinal values assigned to levels of the variable under study. The gene-gene and gene-nutrient interactions were statistically evaluated based on the likelihood ratio test, comparing the model including a term or terms for interaction with the model without. Statistical significance was declared if two-sided P was less than 0.05. Statistical analyses were carried out using SAS version 9.2 (SAS Institute, Cary, NC).

**Results**

Table 1 shows selected characteristics of colorectal cancer cases and controls. Cases were slightly older than controls, had higher body mass index, more sedentary in their job, and physically more active in leisure time. Heavy alcohol use and parental colorectal cancer were more frequent in cases than in controls. No significant difference was observed between cases and controls with respect to smoking and total energy intake. Average daily intakes of methionine and vitamin B₁₂ were lower in cases than in controls. There was no measurable difference in the intake of folate, vitamin B₁₂, or vitamin B₁₂ between cases and controls.

In cases and controls combined, main sources of
Folate intake were vegetables (36%) and green tea (16%) followed by cereals (7%), fruits (7%), and liver (7%). Methionine were derived largely from fish and shellfish (29%), meats (19%), and cereals (22%). Vitamin B12 intake was derived from a variety of animal and plant foods including cereals (11%), vegetables (8%), legumes (7%), green tea (13%), fish and shellfish (12%), meats and liver (12%), and milk and dairy products (13%). Dietary sources of vitamin B6 were also diverse, main foods being vegetables (21%), fruits (10%), fish and shellfish (20%), and meats (12%). The majority of vitamin B12 intake was due to consumptions of fish and shellfish (71%) and meats (16%). Calcium intake was positively correlated with each of the nutrients under study, with Spearman r ranged 0.47-0.66 in the control group, and n-3 PUFA intake was most strongly correlated with methionine (Spearman r 0.63) and vitamin B12 (Spearman r 0.56).

Higher intakes of methionine and vitamin B12 were each associated with a decreased risk of colorectal cancer with a statistically significant trend when the dietary factors were not taken into account (Table 2). After adjustment for intakes of calcium and n-3 PUFA, the inverse associations with methionine and vitamin B12 disappeared. Intakes of folate, vitamin B6, and vitamin B12 were unrelated to colorectal cancer risk regardless of adjustment for calcium and n-3 PUFA intakes.

Table 1. Selected Characteristics of Cases of Colorectal Cancer and Controls

| Variable                                      | Cases (n=181) | Controls (n=181) | p*             |
|------------------------------------------------|---------------|------------------|----------------|
| Mean (μg/day)                                  | 3.41          | 3.57             | 0.07           |
| Age (year), mean                               | 71.4          | 69.5             | 0.04           |
| Body mass index (kg/m²), mean†                | 24.5          | 24.2             | 0.29           |
| Ever smoking (%)                               | 13.2          | 13.7             | 0.22           |
| Alcohol use (%)                                | 11.1          | 11.2             | 0.90           |
| High alcohol use, ≥1 units/day (%)‡           | 31.0          | 33.3             | 0.14           |
| Leisure-time activity, ≥16 MET-hr/week (%)§    | 25.1          | 26.2             | 0.35           |
| Parental colorectal cancer (%)‡               | 7.9           | 8.4              | 0.19           |
| Energy intake (kcal/day), geometric mean†     | 2154          | 2146             | 0.76           |
| Micronutrient intake, geometric mean†         | 355           | 355              | 0.91           |

Table 2. Colorectal Cancer Risk According to Energy-adjusted Intakes of Folate, Methionine, and Vitamin B

| Micronutrient | Q1 (low) | Q2 | Q3 | Q4 | Q5 (high) | p*|
|---------------|----------|----|----|----|-----------|---|
| Folate (μg/day) | 234      | 300 | 355 | 417 | 522 | 0.82 |
| OR (95% CI)**  | 1.00      | 0.95 (0.69-1.31) | 0.90 (0.65-1.24) | 1.03 (0.75-1.43) | 0.93 (0.66-1.32) | 0.90 |
| Methionine (mg/day) | 1.00      | 0.98 (0.71-1.37) | 0.96 (0.68-1.35) | 1.18 (0.83-1.68) | 1.14 (0.78-1.68) | 0.31 |
| OR (95% CI)**  | 1.00      | 1.35 (1.05-1.73) | 1.48 (1.15-1.93) | 1.68 (1.31-2.16) | 1.82 (1.42-2.32) | 0.31 |
| Vitamin B12 (mg/day) | 1.00      | 1.29 (0.94-1.77) | 1.45 (1.09-1.95) | 1.56 (1.19-2.03) | 1.61 (1.24-2.09) | 0.31 |
| OR (95% CI)**  | 1.00      | 1.91 (1.66-2.21) | 1.79 (1.53-2.11) | 1.59 (1.32-1.95) | 1.40 (1.15-1.71) | 0.66 |
| Vitamin B6 (mg/day) | 1.00      | 0.97 (0.67-1.41) | 1.29 (0.96-1.74) | 1.44 (1.07-1.91) | 1.17 (0.80-1.74) | 0.32 |
| OR (95% CI)**  | 1.00      | 1.19 (0.79-1.50) | 0.87 (0.63-1.22) | 0.90 (0.63-1.28) | 0.99 (0.69-1.43) | 0.72 |
| Vitamin B12 (mg/day) | 1.00      | 0.97 (0.66-1.41) | 1.29 (0.96-1.74) | 1.44 (1.07-1.91) | 1.17 (0.80-1.74) | 0.32 |
| OR (95% CI)**  | 1.00      | 1.00 (0.79-1.50) | 0.87 (0.63-1.22) | 0.90 (0.63-1.28) | 0.99 (0.69-1.43) | 0.72 |
| Vitamin B12 (mg/day) | 1.00      | 1.00 (0.83-1.16) | 0.96 (0.68-1.37) | 1.38 (0.96-1.98) | 1.15 (0.78-1.71) | 0.30 |
| OR (95% CI)**  | 1.00      | 1.00 (0.83-1.16) | 0.96 (0.68-1.37) | 1.38 (0.96-1.98) | 1.15 (0.78-1.71) | 0.30 |

*Unpaired t-test for mean and chi-square test for proportions, unless otherwise specified; †Adjusted for sex and 5-year age class by analysis of covariance; ‡Adjusted for sex and age class (<55, 55-64, and >65 years) by the direct method with numbers of cases and controls combined as standard population. p* was based on the Mantel-Haenszel method; †Energy-adjusted intake per 2000 kcal/day based on the regression residual method; **Number of cases/controls; ††Adjusted for sex, age (5-year class), resident area, cigarette smoking, alcohol consumption, body mass index, type of job, leisure-time physical activity, and parental colorectal cancer; †‡Further adjusted for dietary intakes of calcium and n-3 polyunsaturated fatty acids (quintiles).
Table 3. *MTR*, *MTRR* and *TSER* Polymorphisms and Colorectal Cancer Risk

| Genotype | Cases No. (%) | Controls No. (%) | Crude OR (95% CI) | Adjusted OR (95% CI)* |
|----------|---------------|-----------------|-------------------|-----------------------|
| *MTR* 2756A>G | | | | |
| AA  | 449 (65.6) | 525 (67.6) | 1.00 (referent) | 1.00 (referent) |
| AG  | 218 (31.9) | 228 (29.3) | 1.12 (0.89-1.40) | 1.12 (0.89-1.41) |
| GG  | 17 (2.5) | 24 (3.1) | 0.83 (0.44-1.56) | 0.81 (0.42-1.55) |
| *MTRR* 66A>G | | | | |
| AA  | 342 (49.9) | 361 (46.4) | 1.00 (referent) | 1.00 (referent) |
| AG  | 278 (40.6) | 343 (44.1) | 1.09 (0.88-1.36) | 1.09 (0.87-1.37) |
| GG  | 65 (9.5) | 74 (9.5) | 0.86 (0.69-1.06) | 0.83 (0.67-1.04) |
| *TSER* 26-bp repeat | | | | |
| 3R/3R  | 451 (68.3) | 555 (74.3) | 1.00 (referent) | 1.00 (referent) |
| 2R/2R  | 187 (28.3) | 176 (23.6) | 0.93 (0.64-1.34) | 0.90 (0.62-1.31) |
| 2R/2R  | 22 (3.3) | 16 (2.1) | 0.87 (0.71-1.07) | 0.85 (0.69-1.04) |
| 3R/2R+2R/2R  | 209 (31.7) | 192 (25.7) | 1.69 (0.88-3.26) | 1.80 (0.92-3.54) |

*Adjusted for sex, age, resident area, cigarette smoking, alcohol consumption, body mass index, type of job, leisure-time physical activity, and parental colorectal cancer; †Subjects with 4- or 5-repeat allele were excluded (25 cases and 31 controls).

Table 4. Joint Effects of *MTHFR* TT Genotype and *MTR*, *MTRR* and *TSER* Genotypes on Colorectal Cancer Risk

| Genotype | Cases n* | Controls n* | Crude OR (95% CI) | Adjusted OR (95% CI)† |
|----------|-----------|-------------|-------------------|-----------------------|
| *MTR* 2756A>G | | | | |
| AA  | 401/438 | 1.34 (1.06-1.69) | 1.33 (1.05-1.68) |
| AG  | 198/206 | 1.69 (0.88-3.26) | p = 0.01 |
| GG  | 26/34 | 0.94 (0.67-1.32) | 0.90 (0.62-1.31) |
| *MTRR* 66A>G | | | | |
| AA  | 342/361 | 0.87 (0.64-1.34) | 0.85 (0.69-1.04) |
| AG  | 278/343 | 1.12 (0.89-1.40) | 1.12 (0.89-1.41) |
| GG  | 65/74 | 0.86 (0.69-1.06) | 0.83 (0.67-1.04) |
| *TSER* 26-bp repeat | | | | |
| 3R/3R  | 451/555 | 1.00 (referent) | 1.00 (referent) |
| 2R/2R  | 187/176 | 0.93 (0.64-1.34) | 0.90 (0.62-1.31) |
| 2R/2R  | 22/16 | 0.87 (0.71-1.07) | 0.85 (0.69-1.04) |
| 3R/2R+2R/2R  | 209/192 | 1.69 (0.88-3.26) | 1.80 (0.92-3.54) |

*Number of cases/controls; †Adjusted for sex, age, resident area, cigarette smoking, alcohol consumption, body mass index, type of job, leisure-time physical activity, and parental colorectal cancer

Table 5. Adjusted Odds Ratios (95% confidence intervals) of Colorectal Cancer for *TSER* Genotypes, with Stratification by Dietary Intake of Folate-related Nutrient and Alcohol

| Nutrient/genotype | Low | Dietary intake* | p interaction |
|-------------------|-----|-----------------|--------------|
| Folate | 3R/3R | 1.00 (referent) | 1.12 (0.80-1.57) | 0.79 (0.57-1.10) |
| 3R/2R+2R/2R | 1.07 (0.68-1.78) | 1.43 (0.93-2.20) | 1.80 (1.15-2.82) |
| Methionine | 3R/3R | 1.00 (referent) | 0.94 (0.67-1.32) | 0.89 (0.59-1.35) |
| 3R/2R+2R/2R | 1.18 (0.77-1.81) | 1.08 (0.70-1.67) | 1.58 (0.99-2.54) |
| Vitamin B₁ | 3R/3R | 1.00 (referent) | 0.92 (0.65-1.30) | 1.04 (0.70-1.54) |
| 3R/2R+2R/2R | 1.05 (0.78-1.45) | 1.38 (0.86-2.39) | 1.60 (1.01-2.58) |
| Vitamin B₂ | 3R/3R | 1.00 (referent) | 1.00 (0.71-1.41) | 1.16 (0.79-1.69) |
| 3R/2R+2R/2R | 1.30 (0.85-1.99) | 1.18 (0.77-1.82) | 1.83 (1.15-2.91) |
| Alcohol | 3R/3R | 1.00 (referent) | 1.10 (0.79-1.53) | 1.02 (0.70-1.50) |
| 3R/2R+2R/2R | 1.45 (0.94-2.24) | 1.64 (1.08-2.48) | 1.11 (0.69-1.78) |

*Intake was categorized at tertiles in the control group, except for alcohol intake (0, <1, and ≥1 units/day); †Adjusted for sex, age, area, cigarette smoking, alcohol consumption (for nutrients), body mass index, type of job, physical activity, parental colorectal cancer, and dietary intakes of calcium and n3-polyunsaturated fatty acids

Discussion

Dietary intakes of methionine and vitamin B₁ were associated with a decreased risk of colorectal cancer, but the associations were confounded by dietary intakes of calcium and n-PUFA. Dietary intakes of folate, vitamin...
B<sub>12</sub> and vitamin B<sub>6</sub> showed no association with colorectal cancer risk even when intakes of calcium and n-PUFA were not taken into consideration. The TSER 2R allele was dose-dependently associated with an increased risk of colorectal cancer, the increase being more evident when intake of folate, methionine, vitamin B<sub>2</sub>, or vitamin B<sub>6</sub> was high or when alcohol was not consumed.

The present study did not show a protective association with either folate or vitamin B<sub>2</sub> in a Japanese population. Use of folate and vitamin B<sub>2</sub> supplements was not considered in the present study. However, non-dietary intakes of these vitamins were probably small in the study population. Foods are not enriched with folic acid in Japan. No more than 64 subjects (31 cases and 33 controls) reported that they had used specific vitamin B complex or B-containing multivitamins daily at least for 5 years, and none of these specified multivitamins contained folic acid. Thus folate or vitamin B<sub>2</sub> intake may have lower in the present population than in North America, where folate fortification is mandatory and supplements are commonly used (Kim, 2008). While an earlier meta-analysis suggested that dietary folate intake, rather than total folate intake, was more strongly related to a decreased risk of colorectal cancer (Sanjoaquin et al., 2005), a recent pooled analysis of prospective studies in North America and Europe indicated that the decrease in colorectal cancer risk was greater for total folate intake than for dietary folate intake (Kim et al., 2010). As for vitamin B<sub>12</sub> supplement use accounted for the majority of total intake and resulted in a wider range of the distribution of the intake in some study populations in North America (Larsson et al., 2010). Nonetheless, dietary intake of vitamin B<sub>2</sub> was shown to be related to a decreased risk of colorectal cancer in different populations worldwide, although the findings are not necessarily consistent (Theodoratou et al., 2008; Larsson et al., 2010; Zhang et al., 2012; Zschäbitz et al., 2013). The findings on methionine, vitamin B<sub>2</sub>, and vitamin B<sub>6</sub>, are in agreement with the observation in the majority of the previous studies (Harnack et al., 2002; Le Marchand et al., 2002; 2009; Ishihara et al., 2007; Mutruga et al., 2007; Sharp et al., 2008; Weinstein et al., 2008; Shrubssole et al., 2009).

The present findings on the TSER polymorphism are contrary to the results from the studies in the United States (Chen et al., 2003; Ulrich et al., 2005), in which individuals with the TSER 2R/2R genotype showed a decreased risk of colorectal cancer. It is known that patients of colorectal cancer with the TSER 3R/3R genotype respond less to 5-FU-based chemotherapy (Winder and Lenz, 2010), but it remains uncertain how the TS activity is involved in colorectal carcinogenesis. It is possible that the role for the TSER polymorphism in folate metabolism may differ in different ethnicities. The TSER 2R allele is very common in Caucasians (Chen et al., 2003; Ulrich et al., 2005), but rare in Asians (Trinh et al., 2002). The TSER 2R allele was associated with lower concentrations of plasma folate in Caucasians (Chen et al., 2003), but with higher folate concentrations in Chinese (Trinh et al., 2002). Decreased risk of colorectal cancer associated with the MTHFR 677TT genotype is putatively ascribed to proper DNA synthesis and repair due to a greater supply of methyleneTHF (Ulrich, 2005). Thus an increased risk associated with the TSER 2R allele is mechanically compatible with the folate-related pathway in colorectal carcinogenesis. Interestingly, an increased risk associated with the TSER 2R allele was pronounced in the high folate status. The findings are seemingly paradoxical, but the effect of lowered TS expression could be more discernible when the supply of methyleneTHF is sufficient.

The present study showed that decreased risk with the MTHFR 677TT genotype was more evident when vitamin B<sub>12</sub> intake was lower. Again, the finding is contradictory to the observation in the United States; a decreased risk with the MTHFR 677TT genotype was observed in the second and third tertiles, not in the lowest tertile, of dietary vitamin B<sub>12</sub> in the Multiethnic Cohort study (Le Marchand et al., 2005). Low levels of vitamin B<sub>12</sub> further reduce the enzyme activity, and thereby accentuating the pool of methyleneTHF. In earlier prospective studies in the United States (Chen et al., 1996; Ma et al., 1997), a decreased risk of colorectal cancer with the MTHFR 677TT genotype was observed specifically among individuals with high folate intake. While the initial observation was replicated in the Multiethnic Cohort study (Le Marchand et al., 2005; 2009), such an effect modification has not been confirmed in other studies in the United States and other countries (Kono and Chen, 2005). A decreased risk associated with MTHFR 677TT genotype or the 677CT/TT genotype was more pronounced in those with low folate intake in Scotland (Sharp et al., 2008) and Japan (Matsuo et al., 2005). The MTHFR 677TT genotype was unrelated to colorectal cancer risk regardless of plasma folate levels in the EPIC study (Eussen et al., 2010). On the other hand, a decreased risk associated with the MTRR 677TT genotype has been more consistently observed among those with null or modest alcohol consumption (Kono and Chen, 2005; Le Marchand et al., 2005; Sharp et al., 2008).

The lack of an association between MTR 2756A>G and colorectal cancer in the present study is in agreement with the findings in some of the previous studies (Harnack et al., 2002; Ulrich et al., 2005; Theodoratou et al., 2008; Eussen et al., 2010), but not in others (Ma et al., 1999; Ulvik et al., 2004; Matsuo et al., 2005; de Vogel et al., 2009). A recent meta-analysis concluded that MTR 2756A>G was unrelated to colorectal cancer risk (Ding et al., 2013). The MTR 2756GG genotype was associated with a decreased risk of colorectal cancer in individuals with high plasma folate or low alcohol consumption (Ma et al., 1999) and in those with low concentrations of plasma homocysteine (Ulvik et al., 2004). Another study showed an increased risk for the MTR 2756GG genotype among alcohol drinkers (Matsuo et al., 2005). We did not separate the MTR 2756GG genotype in the analysis on the genotype interaction because individuals with the MTR 2756GG genotype were very few. In a repeated analysis separating the MTR 2756GG genotype, however, there was no effect modification of alcohol on the association with the MTR 2756GG genotype. Adjusted OR for alcohol consumptions of 0, <1, and 1 units/day among those with the MTR 2756GG genotype were 1.20 (95%CI 0.49-2.93), 0.73 (0.06-8.94), and 0.72 (0.23-2.28), respectively, as compared with non-alcohol drinkers with MTR 2756AA.
genotype ($p_{\text{interaction}} = 0.73$). The null association with the $MTRR$ 66A>G is consistent with the previous observation in a limited number of studies in Caucasians (Le Marchand et al., 2002; Theodoratou et al., 2008; de Vogel et al., 2009; Eussen et al., 2010).

The use of community controls were among strengths of the present study. The frequencies of the $MTR$ 2756G, $MTRR$ 66G, and $TSER$ 2R alleles in the control group were very similar to those reported elsewhere in Japan (Matsuo et al., 2005). A limitation of the present study was that the participation rate in terms of the genotyping was not optimal. However, the participation was relatively similar in cases (65%) and controls (56%), and it is unlikely that the participation was associated with genotype and thus that selection bias occurred with respect to the polymorphisms under study. Another limitation was the retrospective assessment of intake of folate-related nutrients and alcohol consumption. Recent dietary intake may not have captured the intakes directly relevant to the development of colorectal cancer. Finally, although the total number of subjects was fairly large, the sample size was much smaller in the analyses on the gene-gene and gene-nutrient interactions.

In summary, a case-control study in Japan showed no association of dietary intake of folate and related nutrients with colorectal cancer and showed a modest increase in the risk associated with the $TSER$ 2R allele.

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