ABSTRACT

Hepatocellular carcinoma is the most common primary liver malignancy and is an international public health concern, constituting one of the most deadly cancers worldwide. Infection with hepatitis B virus and hepatitis C virus is a major risk factor for HCC in developed countries. Emerging evidence indicates that there are other important lifestyle factors that contribute to the international burden of HCC, such as alcohol consumption, diabetes, obesity, and the intake of aflatoxin-contaminated food. Obesity and diabetes are also likely to be risk factors for HCC, the most frequent subtype of liver cancer. The chief pathway by which obesity increases risk involves the association between obesity and nonalcoholic fatty liver disease (NAFLD). Coffee consumption has been studied extensively and appears to have a favorable effect on the prevention of liver diseases, including HCC. One hypothesis suggests that coffee intake lowers serum levels of gamma-glutamyltransferase (GGT), which is associated with a lower incidence of HCC. It is estimated that more than 80% of HCC cases are attributable to four principal causes that are avoidable. It is difficult to make dietary recommendations, because it is unknown whether consuming higher amounts of specific antioxidants will decrease the risk of developing hepatocellular carcinoma. A diet rich that is in polyunsaturated fatty acids and, possibly, B-carotene could reduce the risk of HCC, and high dietary GL is associated with an increased risk independently of cirrhosis or diabetes.
ers has been also proposed as a mechanism through which HCC develops (14).

Obesity is another risk factor for several chronic diseases, including hypertension, insulin resistance (IR), type 2 diabetes, dyslipidemia, and chronic heart disease (15). Collectively, abdominal obesity, IR, dyslipidemia, and elevated blood pressure are known as the metabolic syndrome, reflecting overnutrition, a sedentary lifestyle, and resultant excess adiposity, which is associated with a chronic proinflammatory state (15, 16). Notably, obesity and diabetes are also likely to be risk factors for HCC, the most frequent subtype of liver cancer. The chief pathway by which obesity increases risk involves the association between obesity and nonalcoholic fatty liver disease (NAFLD) (17). NAFLD is the most common cause of chronic liver disease among adults in western countries (18). NAFLD comprises a spectrum of conditions, ranging from fat alone to fat plus inflammation, fat plus ballooning degeneration, and nonalcoholic steatohepatitis (NASH), which is a well-recognized cause of cirrhosis and has been increasingly associated with the development of carcinoma.

As the hepatic entity of metabolic syndrome, NAFLD/NASH is a risk factor for HCC, even in the absence of cirrhosis (19). A recent study has shown that NAFLD is a principal risk factor in the development of HCC, irrespective of age (20). Accumulating evidence also suggests that visceral adipose tissue secretes vascular endothelial growth factor (VEGF) and other adipokines, implicating the dysregulation of angiogenesis as a connection between obesity and worse clinical outcome (21). In animal models, leptin promotes angiogenesis and thus can facilitate the progression of NASH to HCC (22). Leptin also activates many signal transduction pathways, such as JNK, protein kinase B, AKT, and the extracellular signal-regulated kinase pathway in HCC cells, all of which promote the progression of cancer (23).

In addition to increasing the prevalence of chronic liver disease, diabetes is an independent risk factor for the development of HCC. In a recent systematic review of 13 case control studies, 11 reports supported an association between diabetes and the development of HCC (24). Of the 13 case control studies, subjects with diabetes had a 2-fold higher risk of HCC (24). The presence of diabetes remained an independent risk factor of HCC after adjusting for alcohol use or viral hepatitis (10, 11). Many case reports and case reviews of diabetes and the development of HCC have supported the association of diabetes and viral hepatitis (10, 11). Several mechanisms, involving fat, iron, heterocyclic amines, and N-nitroso compounds, link meat intake with chronic liver disease and hepatocellular carcinoma. Notably, amino acid-defined diets that are deficient in methionine and cysteine increase body fat, and saturated fat is associated with increased chronic liver disease (CLD) and hepatocellular carcinoma (31). Several mechanisms, involving fat, iron, heterocyclic amines, and N-nitroso compounds, link meat intake with chronic liver disease and hepatocellular carcinoma. Notably, amino acid-defined diets that are deficient in methionine and cysteine increase body fat, and saturated fat is associated with increased chronic liver disease (CLD) and hepatocellular carcinoma.

Another important risk factor for the development of HCC is the contamination of foodstuffs with aflatoxin B1 (AFB1). AFB1 is a mycotoxin that is produced by the fungus Aspergillus, which grows readily on food when it is stored under warm, damp conditions (33, 34). When ingested, it is metabolized into the active AFB1-exo-8, 9-epoxide, which binds to DNA and causes damage, such as mutations in the p53 tumor suppressor gene. This mutation has been reported in 50% of HCC tumors in southern Africa, where aflatoxin B1 is a known risk factor for HCC (33, 35). A prospective case control study from China of 18,244 middle-aged men demonstrated that individuals who expressed urinary aflatoxin biomarkers had a significantly greater risk of HCC after adjustments for HBV surface antigen seropositivity and cigarette smoking. Recent research suggests that the intake of several dietary antioxidants (e.g., coenzyme Q10, vitamin C and E, selenium) and phytochemicals (e.g., ellagic acid, curcumin, lycopene, epigallocatechin gallate, and resveratrol) that are present in fruit, vegetables, herbs and medicinal plants can prevent cardiovascular abnormalities, neurodegeneration, and hepatocarcinogenesis (36, 37). These phytochemicals not only have antioxidant properties but also activate cellular stress response pathways through the induction of kinases and transcription factors, leading to the expression of antioxidants and phase II enzymes. Activation of the Nrf2 transcription factor-antioxidant response element (ARE) pathway by these phytochemicals effects cytoprotection and chemoprevention (38).

However, the hermetic effects of these phytochemicals must be considered, because at low doses they have stimulatory effects but are toxic at higher doses (39). Various studies from Japan and Europe have found that those who consume large amounts of green vegetables have a significantly lower

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risk of developing HCC (39, 40). One study has demonstrated that the daily consumption of green vegetables, compared with several times per week, has a protective effect against the development of HCC. In contrast, a Greek study failed to note an association between vegetable intake and a reduction in the risk of developing HCC (41). In conclusion, more than 80% of HCC cases are estimated to be attributed to four principal causes that are avoidable. Hepatitis-negative HCC in men is effected primarily by heavy alcohol consumption. Diet is involved in the risk of HCC; specifically, the beneficial effect of certain dietary products, such as fruits and vegetables, is independent of other major risk factors (e.g., HBV and HCV infections).

Due to conflicting results, it is difficult to make dietary recommendations, because it is unknown whether consuming higher amounts of specific antioxidants will decrease the risk of developing hepatocellular carcinoma. A diet that is rich in polyunsaturated fatty acids and, possibly, β-carotene can reduce the risk of HCC, and high dietary GL is associated with increased risk, independently of cirrhosis or diabetes. Coffee has favorable effects, as shown in many studies, especially in HCV infection.

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Conflict of interest
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