Letters to the Editor


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The paper by Byrne et al., “Predictors of Dietary Heterocyclic Amine Intake in Three Prospective Cohorts” (1), continues the trend toward estimation of carcinogen intake by dietary questionnaire. They seem to have missed the one paper that combined both analytical chemistry and dietary information (Ji et al.; Ref. 2).

The take-home lessons are:
(a) Until the analytical chemistry in the 1994 study was completed (2), the role of bacon and sausage as a source of heterocyclic amines was not known.
(b) Ethnic practices in cooking and food selection are important. How valid could it be to compare individuals from Sweden to African-Americans in Los Angeles?
(c) Byrne et al. (1) can keep manipulating the minute quantity of real analytical data currently available, but the sample is too small to be meaningful.
(d) If Byrne et al. (1) want to improve the questionnaires, they should invest the time and effort in getting more data on real populations, not on a chef’s idea of how to cook chicken.
(e) Had Byrne et al. (1) read the paper by Ji et al. (2), they might actually have been able to test their model questionnaire.

References

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We were aware of the article by Ji et al. (1) that Dr. Tannenbaum mentions in his letter (2) commenting on our paper (3). Because the study by Ji et al. (1) compared frequency of intake of 11 foods with urinary levels of MelQx2 among 76 participants who provided both urine and food data and did not measure the HCA concentration in the food (1), the results were not directly related to our study (3).

In response to Dr. Tannenbaum’s “lessons”:
(a) Ji et al. (1) did provide information on the association between reported frequency of bacon consumption and urinary concentration of MelQx. However, metabolic studies have shown that urinary MelQx levels reflect short-term (within 12 h) and not long-term intake of MelQx (4). Thus, only if there is little variation in daily intake will one measure of urinary MelQx reflect the relevant long-term usual exposure. Consistent intake of HCA is unlikely, given that recent analytical studies (4–7) showed significant variation in HCA levels in different foods and in the same food, depending on how the food was cooked (cooking methods) and the degree of doneness (outside appearance).
(b) We agree with Dr. Tannenbaum that ethnic differences in cooking and food selection are important. This point was emphasized in the discussion of our paper (3), in which we indicated that, “in other populations, different questions may be necessary to measure the variation in dietary HCA exposure.”
(c) Concerns regarding the appropriate use of real analytical data and meaningful study size are central to any epidemiological study. We sought to identify an alternative method to existing food frequency questions to better assess variation in HCA intake. We agree with Dr. Tannenbaum that larger studies are needed to determine whether HCA intake is related to risk of developing specific cancers. For this reason, we have included the relevant questions we identified from our study of 673 randomly selected participants in subsequent question-
naires mailed to the entire NHS and HPFS cohorts. With future follow-up, we will be able to ascertain whether differences in reported HCA intake are associated with risk of specific cancers.

(d) The more than 280,000 participants in the NHS, NHS II, and HPFS are not a representative sample of the United States population, although they are, indeed, "real populations." The dedication and commitment to the research effort by these participants provides meaningful information to many people beyond those in the studies themselves. We asked participants to report how the food they usually eat was cooked and its appearance. The database for HCA levels was created by cooking and testing multiple samples of each meat/method/doneness combination.

(e) As indicated in response (a) above, the results from the study by Ji et al. (1), although very interesting, did not provide the information necessary for us to conduct our study. However, our study results help to explain why Ji et al. (1) found that urinary MeIQx levels were associated with reported intake of bacon but not with other foods. If they had ascertained information about cooking methods and degree of doneness for other foods, they may have noted an association (4). Our study found that, to estimate the intake (not excretion) of HCA from bacon in these three United States cohorts, we needed to ascertain only frequency of consumption (3). For other foods, additional information regarding cooking methods and degree of doneness was necessary to assess variation in HCA levels (3).

References

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