

1 **Green tea consumption and risk of hematologic neoplasms: the Japan Collaborative**  
2 **Cohort Study for Evaluation of Cancer Risk (JACC Study)**

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18 **Acknowledgements**

19 We express our appreciation to Drs Kunio Aoki and Yoshiyuki Ohno, Professors Emeriti of  
20 the Nagoya University School of Medicine and former chairpersons of the JACC Study.

1 We are also greatly indebted to Dr Haruo Sugano, former Director of the Cancer Institute,  
2 Tokyo, who greatly contributed to the initiation of the JACC Study; Dr Tomoyuki  
3 Kitagawa, Director Emeritus of the Cancer Institute of the Japanese Foundation for Cancer  
4 Research and former chairman of the Grant-in-Aid for Scientific Research on the Priority  
5 Area ‘Cancer’; and Dr Kazao Tajima of the Aichi Cancer Center, who was the previous  
6 chairman of the Grant-in Aid for Scientific Research on Priority Areas of Cancer  
7 Epidemiology, for their warm encouragement and support of this study. A complete  
8 membership list appears in the Appendix. We are also grateful to Ms Flaminia Miyamasu,  
9 Medical English Communications Center (MECC), University of Tsukuba, for providing  
10 editorial assistance. We also thank Ms Utako Murai, Ms Rie Usuki, and Dr Tomomi Kihara  
11 for providing technical assistance.

12

13

14 **Financial supports:**

15 The JACC Study was supported by Grants-in-Aid for Scientific Research from the Ministry  
16 of Education, Culture, Sports, Science and Technology of Japan (MEXT) (Monbusho);  
17 Grants-in-Aid for Scientific Research on Priority Areas of Cancer; and Grants-in-Aid for  
18 Scientific Research on Priority Areas of Cancer Epidemiology from MEXT  
19 (MonbuKagaku-sho) (Nos. 61010076, 62010074, 63010074, 1010068, 2151065, 3151064,  
20 4151063, 5151069, 6279102, 11181101, 17015022, 18014011, 20014026, 20390156, and  
21 26293138); and JSPS KAKENHI grant number JP 16H06277.

1 **Conflict of interest:** The authors have no conflicts of interest to declare.

2

1 **Abstract**

2 **Purpose** Experimental studies suggested that green tea may have an anticancer effect on  
3 hematologic neoplasms. However, few prospective studies have been conducted.

4 **Methods** A total of 65,042 individuals aged 40 to 79 years participated in this study and  
5 completed a self-administered questionnaire about their lifestyle and medical history at  
6 baseline (1988–1990). Of these, 52,462 individuals living in 24 communities with  
7 information on incident hematologic neoplasms available in the cancer registry, who did  
8 not have a history of cancer and provided valid information on frequency of green tea  
9 consumption were followed through 2009. Hazard ratios (HRs) and 95% confidence  
10 intervals (CIs) for the incidence of hematologic neoplasms according to green tea  
11 consumption were analyzed.

12 **Results** The incidence of hematologic neoplasms during a median follow-up of 13.3-years  
13 was 323. Compared with the never green tea drinkers, the multivariate HRs and 95% CIs  
14 for total hematologic neoplasms in green tea drinkers of  $\leq 2$  cups/day, 3–4 cups/day, and  $\geq 5$   
15 cups/day were 0.65 (0.42–1.00), 0.73 (0.47–1.13), and 0.63 (0.42–0.96), respectively. The  
16 association was more prominent for acute myeloid leukemias and follicular lymphomas.

17 **Conclusions** The present cohort study suggests a protective effect of green tea against  
18 hematologic neoplasms, especially acute myeloid leukemias.

19

20 **Keywords** Epigallocatechin-3-gallate, Hematologic neoplasm, Japan Collaborative Cohort  
21 Study for Evaluation of Cancer Risk, Preventive medicine, Green tea, Acute myeloid  
22 leukemia

## 1 **Introduction**

2 Experimental studies have suggested that consumption of green tea may prevent various  
3 cancers including hematologic neoplasms[1-3]. Green tea constituents such as  
4 epigallocatechin-3-gallate (EGCG) induce apoptosis in a variety of cancer cells including  
5 human myeloid leukemia cells[4-6]. EGCG induces apoptosis of acute myeloid leukemia  
6 cells by increasing the amount of intracellular reactive oxygen species[6]. However, the  
7 epidemiologic evidence is limited and controversial. A previous Japanese cohort study  
8 showed that a higher frequency of green tea consumption was associated with a lower risk  
9 of hematologic neoplasms[7]. Meanwhile, another Japanese cohort study found no  
10 significant association between green tea consumption and the risk of acute myeloid  
11 leukemia or myelodysplastic syndromes[8]. Case-control studies conducted in Taiwan[9]  
12 and China[10] reported that high intake of green tea was associated with lower risk of  
13 leukemias such as myeloid leukemia.

14         The incidence of hematologic neoplasms is known to be relatively high among  
15 whites and to be relatively low among Asians[11]. Ecologically, tea production in 2013 was  
16 1050 g/person in Asia, 120 g/person in the Americas, and 0.4 g/person in Europe[12]. In  
17 this context, we hypothesized that the difference in the incidence of hematologic neoplasms  
18 between white and Asian populations may be partly explained by green tea consumption.  
19 We used data from a population-based cohort study to examine the association between  
20 green tea consumption and risk of mortality from and incidence of hematologic neoplasms  
21 and their subtypes among Japanese men and women.

1

## 2 **Materials and Methods**

### 3 **Study population**

4 The Japan Collaborative Cohort (JACC) Study for Evaluation of Cancer Risk is a large  
5 community-based prospective study, started between 1988 and 1990. The details of the  
6 JACC study have been reported elsewhere[13]. In brief, a total of 110,585 individuals  
7 (46,395 men and 64,190 women), aged 40 to 79 years and living in 45 communities across  
8 Japan, participated in the study and completed self-administered questionnaires about their  
9 lifestyles and medical histories of cardiovascular disease and cancer. From these  
10 questionnaires, data on frequency of green tea consumption were available for 33,154 men  
11 and 46,028 women. We excluded 15 persons who answered that their daily green tea  
12 consumption was >20 cups/day and 1461 persons who had a history of cancer at baseline.  
13 Among the remaining 77,706 participants (32,733 men and 44,973 women), we involved  
14 52,462 individuals (21,791 men and 30,671 women) living in 24 communities with  
15 information on incident hematologic neoplasms available in the cancer registry. According  
16 to the guidelines of the Council for International Organizations of Medical Science, written  
17 informed consent to participate in this epidemiologic study was obtained from the  
18 participants or community representatives before they completed the questionnaire [14].  
19 The ethics committees of Hokkaido University and the University of Tsukuba approved the  
20 study.

21

## 1 **Assessment of green tea consumption and other variables**

2 The participants were asked to state their average rate of green tea consumption during the  
3 previous year. They could select any of 5 frequency responses: “almost never,” “1–2  
4 cups/month,” “1–2 cups/week,” “3–4 cups/week,” and “almost every day.” Participants  
5 who selected the response “almost every day” were asked to state their average  
6 consumption of green tea in numbers of cups per day. We combined the 4 categories of  
7 consumption (1–2 cups/month, 1–2 cups/week, 3–4 cups/week, and 1–2 cups/day) into the  
8 single category  $\leq 2$  cups/day and classified the categories of consumption as never,  $< 2$   
9 cups/day, 3–4 cups/day, and  $\geq 5$  cups/day. Regarding reproducibility, the Spearman  
10 correlation coefficient between the 2 questionnaires, administered 1 year apart for 85  
11 participants (8 men and 77 women), was 0.79 for green tea[15]. Regarding validity, the  
12 Spearman correlation coefficient between the average of the 2 questionnaires and four 3-  
13 day dietary records and four 1-week dietary records was 0.47 (25.4 cups and 30.1 cups per  
14 week) for green tea[15]. When we restricted the data to the 77 women, the result was  
15 essentially the same.

16 In the baseline questionnaire, we also asked lifestyle questions related to age; sex;  
17 height; weight; smoking status; alcohol intake status; frequency of dietary intakes of fish,  
18 vegetable, meat, and bean products; and educational status (age of the highest school  
19 attainment). Body mass index (BMI) was calculated by dividing the self-reported weight in  
20 kilograms by the square of the self-reported height in meters. The average dietary intakes of

1 fish, vegetable, meat, and bean products were evaluated on the basis of the responses  
2 regarding food frequency and converted to a daily amount of intake[15].

3

#### 4 **Follow-up and assessment of hematologic neoplasms**

5 For each participant, person-years of follow-up was calculated from the date of filling out  
6 the baseline questionnaire to diagnosis of a neoplasm, death, moving out of the community,  
7 or the end of 2009, whichever occurred first; exceptions were made for 4 areas in 1999, 4  
8 areas in 2003, and 2 areas in 2008. The median follow-up was 13.3 years (range, 0.01–21.5  
9 years). The diagnosis of neoplasms was based on a systematic review of the records of local  
10 major hospitals and of the population-based cancer registries conducting the follow-up. The  
11 investigators conducted a systematic review of the death certificates, all of which were  
12 forwarded to the public health center in the area of residency. The mortality data were sent  
13 centrally to the Ministry of Health and Welfare, and the underlying causes of death were  
14 coded according to the 10th Revision of the International Statistical Classification of  
15 Diseases and Related Health Problems (ICD10). In Japan, registration of death is legally  
16 required and is believed to be followed across the country. Thus, all of the deaths that  
17 occurred in the cohort were ascertained by death certificates from a public health center,  
18 except for those of participants who died after they had moved from their original  
19 community, in which case the participant was censored. The incidence data were coded  
20 according to the ICD10. We defined hematologic neoplasms as C810–C969 and D460–  
21 D479, according to the ICD10. The cases were further categorized into lymphoid



1 neoplasms (ICD10 codes C810–C889, C900–C903, C910–C919, C947, and D472);  
2 myeloid neoplasms (ICD10 codes C920–C944, D460–D471, and D473); leukemia of  
3 unspecified cell type (ICD10 codes C950–C959); and other and unspecified malignant  
4 neoplasms of lymphoid, and hematopoietic and related tissue (ICD10 codes C960–C969).  
5 Lymphoid neoplasms were further categorized into Hodgkin lymphomas (C810–C819) and  
6 non-Hodgkin lymphomas (C820–C919, C947, and D472). Non-Hodgkin lymphomas were  
7 further categorized into B cell non-Hodgkin lymphomas (C820–C829, C830–C839, C851,  
8 C852, C857, C880–C884, C900–C903, C911–C914, C918, D472); T/NK cell non-Hodgkin  
9 lymphomas (C840–C849, C860–C866, C915–C917, C947); acute lymphoid leukemias  
10 (C910); and non-Hodgkin lymphomas, not otherwise specified (C859, C919). B cell non-  
11 Hodgkin lymphoma were further categorized into follicular lymphomas (C820–C829);  
12 diffuse large B cell lymphomas (C833); plasma cell neoplasms (C900–C903); and chronic  
13 lymphocytic leukemia/small lymphocytic lymphomas (C911, C830). Myeloid neoplasms  
14 were further categorized into acute myeloid leukemias (C920, C924–C926, C928, C930,  
15 C940, and C942); chronic myeloid leukemias (C921, C922, and C931); monocytic  
16 leukemias, unspecified (C939); myelodysplastic syndromes (D460–D469); and chronic  
17 myeloproliferative diseases (D471).

18

## 19 **Statistical analysis**

20 The age-adjusted means and proportions of potential confounding variables were calculated  
21 according to each category of green tea consumption, and the overall difference across the

1 categories was tested by analysis of covariance. Age- and sex-adjusted and area-stratified  
2 hazard ratios (HRs) and 95% confidence intervals (CIs) for hematologic neoplasms were  
3 calculated in each category of green tea consumption and compared with the never-drinker  
4 group by use of the Cox proportional hazards model. In addition, categories of drinkers of  
5  $\geq 1$  cup/month of green tea (ie,  $\leq 2$  cups/day, 3–4 cups/day, and  $\geq 5$  cups/day) were pooled  
6 into the single category (any drinker), and the HRs and 95% CIs for hematologic neoplasms  
7 were calculated. For multivariate analyses, we included the following factors in the models:  
8 age (years); sex; smoking status (never, former, and current of 1–19 or  $\geq 20$  cigarettes/day);  
9 body mass index ( $< 18.5$ , 18.5–20.0, 20.0–23.0, 23.0–25.0, and  $\geq 25.0$  kg/m<sup>2</sup>); alcohol intake  
10 status (never, former, and current  $< 23$ , 23– $< 46$ , 46– $< 69$ , and  $\geq 69$  g ethanol/day based on  
11 the Japanese traditional volume); fish intake as quintiles of the sum of consumption  
12 frequencies of raw fish, boiled fish paste, and dried fish ( $< 22.1$ , 22.4–35.2, 35.2–48.0,  
13 48.2–71.7,  $\geq 72.0$  g/day); vegetable intake as quintiles of the sum of consumption  
14 frequencies of spinach, carrots, tomatoes, cabbage, Chinese cabbage, and edible wild plants  
15 ( $< 51.8$ , 51.9–80.1, 80.1–102.0, 102.1–139.1,  $\geq 139.1$  g/day); meat intake as quintiles of the  
16 sum of consumption frequencies of beef, pork, processed meat, chicken, and liver ( $< 14.2$ ,  
17 14.3–23.5, 23.5–30.4, 30.4–41.9,  $\geq 42.0$  g/day); bean product intake as quintiles of the sum  
18 of consumption frequencies of boiled beans and soybean curd ( $< 14.8$ , 20.0–30.0, 32.0–32.8,  
19 38.6–60.0,  $\geq 62.0$  g/day); energy intake ( $< 1171$ , 1172–1378, 1378–1574, 1574–1859,  $\geq 1859$   
20 kcal/day); and educational status (education until 18 or  $\geq 19$  years of age). Missing data  
21 were allocated to another category for each covariate. The linear trend of HRs across the  
22 average daily consumption of green tea, converting the items of “almost-never” to 0, “1–2

1 cups/month” to 0.05, “1–2 cups/week” to 0.214, “3–4 cups/week” to 0.5, and “almost every  
2 day” to the number of cups of green tea consumed/day, was tested using the Cox  
3 proportional hazards model. To exclude the impact of reverse causation, we also performed  
4 the analyses excluding cases occurring 5 and 10 years from baseline. We also performed the  
5 analyses excluding death certificate-only cases. The proportional hazards assumption was  
6 tested using time by green tea consumption interaction terms and was not violated for each  
7 outcome. All analyses were conducted using the SAS statistical package, version 9.4. The *P*  
8 values for the statistical tests were 2-tailed, and values <0.05 were considered significant.

9

#### 10 **Code availability**

11 The computer code used to generate results that were central to this paper’s conclusions is  
12 available from the corresponding author.

13

#### 14 **Results**

##### 15 **Participant characteristics**

16 The baseline characteristics of the study cohort according to green tea consumption are  
17 shown in Table 1. Both men and women with higher green tea consumption were older than  
18 those who did not drink it. As green tea consumption increased, the proportion of current  
19 smokers was higher in men but lower in women. The proportions of current alcohol drinker  
20 and mean body mass index did not differ markedly by green tea consumption in either men

1 or women. Higher educational attainment was associated with higher consumption of green  
2 tea in both men and women. The mean consumptions of fish, vegetables, meat, beans, and  
3 energy intake were positively associated with green tea consumption in both men and  
4 women.

5

### 6 **Green tea consumption and incidence of hematologic neoplasms**

7 In the 52,462 participants, during a median follow-up of 13.3 years, there were 323 incident  
8 hematologic neoplasms: 219 lymphoid neoplasms (8 Hodgkin lymphomas, 211 non-  
9 Hodgkin lymphomas); 95 myeloid neoplasms (48 acute myeloid leukemias, 10 chronic  
10 myeloid leukemias, 1 monocytic leukemia, unspecified, 34 myelodysplastic syndromes,  
11 and 2 chronic myeloproliferative diseases); 6 leukemias of unspecified cell type; and 3  
12 other and unspecified malignant neoplasms of lymphoid and hematopoietic and related  
13 tissue. Among the non-Hodgkin lymphomas, there were 108 B cell non-Hodgkin  
14 lymphomas; 10 T/NK cell non-Hodgkin lymphomas; 5 acute lymphoid leukemias; and 88  
15 non-Hodgkin lymphomas, not otherwise specified. B cell non-Hodgkin lymphomas  
16 included 10 follicular lymphomas, 16 diffuse large B cell lymphomas, 67 plasma cell  
17 neoplasms, 6 chronic lymphocytic leukemia/small lymphocytic lymphomas, and 9 other B  
18 cell non-Hodgkin lymphomas. The frequency of green tea consumption was nonlinearly  
19 and inversely associated with risk of total hematologic neoplasms (Table 2). The  
20 multivariate HR (95% CI) of all hematologic neoplasms was 0.63 (0.42–0.96) for persons  
21 with  $\geq 5$  cups/day of green tea consumption. The multivariate HR (95% CI) for any green

1 tea drinkers versus never drinkers was 0.66 (0.45–0.98). Such an association was prominent  
2 for acute myeloid leukemias and follicular lymphomas. As for acute myeloid leukemias,  
3 follicular lymphomas, and chronic lymphocytic leukemia/small lymphocytic lymphomas, the  
4 risks were lower in any drinkers. No such association was found for plasma cell neoplasms.  
5 Similar results were observed after the exclusion of cases that occurred 5 and 10 years from  
6 baseline: the multivariate HRs for incident total hematologic neoplasms and acute myeloid  
7 leukemias for persons who drank  $\geq 5$  cups/day of green tea compared with never drinkers  
8 were 0.51 (0.31–0.84) and 0.31 (0.11–0.89), respectively, when early 5-year incidence was  
9 excluded, and 0.51 (0.28–0.94) and 0.37 (0.09–1.47), respectively, when early 10-year  
10 incidence was excluded. Similar results were observed after the exclusion of death  
11 certificate-only cases; the multivariate HRs for incident total hematologic neoplasms and  
12 acute myeloid leukemias for persons who drank  $\geq 5$  cups/day green tea as compared with  
13 never drinkers were 0.64 (0.41–1.01) and 0.36 (0.14–0.95), respectively. We could not  
14 evaluate follicular lymphomas in the same manner because of the small numbers of cases.

15

## 16 **Discussion**

17 In this large prospective study of Japanese men and women, the frequency of green tea  
18 consumption was inversely associated with the incidence of hematologic neoplasms, more  
19 specifically, with the incidence of acute myeloid leukemias and follicular lymphomas. The  
20 exclusion of cases that occurred within 5 and 10 years from baseline did not largely alter  
21 the overall results, nor did the exclusion of death certificate-only cases.

1 Our results extend the evidence obtained from several previous studies of Asian  
2 populations. Two case-control studies from China and Taiwan showed significant inverse  
3 associations between green tea consumption and leukemia[9, 10]. A previous cohort study  
4 of 51,253 Japanese (Ohsaki Study) showed that persons who drank  $\geq 5$  cups of green tea a  
5 day had a lower risk of incident hematologic neoplasms (HR and 95% CI: 0.58, 0.37–0.89)  
6 when compared with those who drank  $< 1$  cup/day, with a threshold of 5 cups/day after  
7 adjustment for age, sex, educational level, cigarette smoking, alcohol consumption, fish  
8 consumption, and soybean products consumption [7]. In that study, the inverse association  
9 was observed mainly for lymphoid neoplasms, not for myeloid neoplasms, although the  
10 neoplasms were not classified into preciser subtypes. Another cohort study of 95,807  
11 Japanese (JPHC Study) with 85 incident acute myeloid leukemias and 70 incident  
12 myelodysplastic syndromes did not find any associations between green tea consumption  
13 and any of the outcomes. [8]. Unlike our study, neither the Ohsaki Study [7] nor the JPHC  
14 Study [8] distinguished never green tea drinkers from the  $< 1$  cup/day category, and this, as  
15 well as the lower statistical power, may be a major reason why those studies did not detect  
16 an association between green tea consumption and risk of acute myeloid leukemias.

17 We consider that the anticancer effects of EGCG, a component of green tea, could explain  
18 our results, although there is poor evidence for the bioavailability of EGCG with  $< 1$   
19 cup/day of green tea consumption. A possible mechanism could be that EGCG induces  
20 apoptosis of cancer cells. Nakazato et al showed that EGCG induced apoptosis in retinoic  
21 acid-resistant acute promyelocytic leukemia and acute myeloid leukemia and that reactive  
22 oxygen species were key mediators of apoptosis induced by EGCG in myeloid leukemic

1 cells[6]. Notably, the apoptosis was observed in myeloperoxidase-positive leukemic cells,  
2 ie, myeloid leukemia cells, but not in myeloperoxidase-negative leukemic cells[16].

3 Another possible mechanism could be that EGCG inhibits cancer cell proliferation through  
4 a cell-surface receptor. Tachibana et al showed that the growth of cells transfected with the  
5 67-kDa laminin receptor was inhibited when the cells were treated with 0.1  $\mu\text{mol/L}$   
6 (equivalent to 2–3 cups of tea[17]) or 1.0  $\mu\text{mol/L}$  (equivalent to 7–9 cups of tea[17])  
7 EGCG[18]. This growth-suppressive effect was completely eliminated when the cells were  
8 treated with anti-67-kDa laminin receptor antibody before the addition of EGCG[17].

9 Montuori et al reported that 42% of acute myeloid leukemia patients had enhanced  
10 expression of the 67-kDa laminin receptor[19]. These lines of biological evidence support  
11 our results and may explain the mechanisms of the observed association between green tea  
12 and hematologic malignancies, especially acute myeloid leukemias.

13 Our study has several limitations. First, we did not have enough information related to  
14 occupational exposures, such as ionizing radiation and benzene, which may affect the risk  
15 of hematologic neoplasms[20]. We believe that the impact of these exposures should not be  
16 very large at the population level. To minimize this impact, we adjusted for potential  
17 confounders in the statistical models, but the residual confounding by unmeasured variables  
18 should still be considered. Second, we did not have information on several risk factors for  
19 hematologic neoplasms, such as family history of hematologic neoplasms, past history of  
20 infection, immunologic disorders and chemotherapy, although these may be less likely to  
21 be correlated with green tea consumption. Third, there might be a measurement error  
22 derived from dietary questionnaires. However, the evaluation of dietary factors by

1 questionnaires was validated by a previous study [15]. Fourth, we only have single  
2 measurements of dietary and lifestyle habits, which may change over time. Fifth,  
3 confounding by dietary components other than green tea should be considered, although we  
4 minimized this confounding by adjusting for as many dietary factors as possible. Sixth, our  
5 assessment of hematologic neoplasms was based on hospital records and death ICD codes.  
6 Although there is no direct evidence of the validity of ICD codes for hematologic  
7 neoplasms, the codes seem quite specific, but probably not sensitive enough to capture  
8 hematologic neoplasms. Thus, the approach used in the current study might have led to an  
9 underestimation of hematologic neoplasm events. Seventh, the quality of the cancer registry  
10 in the present study was not high enough in terms of hematologic neoplasms: the  
11 proportions of death certificate-only incident cases among all hematologic neoplasms and  
12 acute myeloid leukemias were 15% and 4%, respectively. However, the results obtained  
13 after the exclusion of the death certificate-only incident cases did not largely alter the  
14 overall results. Moreover, the accuracy of our cancer registry is the highest when compared  
15 with those of previous reports [7, 8]. Eighth, the number of cases of hematologic neoplasms  
16 in this cohort was modest. However, this is the largest prospective study that has reported  
17 an association between green tea and hematologic neoplasms.

18 In conclusion, the present cohort study suggests a protective effect of green tea against  
19 hematologic neoplasms, especially acute myeloid leukemias.



**Appendix: Study group membership list**

Current members of the JACC Study Group include: Dr. Akiko Tamakoshi (present chairperson of the study group), Hokkaido University Graduate School of Medicine; Dr. Mitsuru Mori, Sapporo Medical University School of Medicine; Dr. Yoshihiro Kaneko, Akita University Graduate School of Medicine; Dr. Ichiro Tsuji, Tohoku University Graduate School of Medicine; Dr. Yosikazu Nakamura, Jichi Medical School; Dr. Hiroyasu Iso, Osaka University School of Medicine; Dr. Kazumasa Yamagishi, Faculty of Medicine, University of Tsukuba; Dr. Haruo Mikami, Chiba Cancer Center; Dr. Michiko Kurosawa, Juntendo University School of Medicine; Dr. Yoshiharu Hoshiyama, Yokohama Soei University; Dr. Naohito Tanabe, University of Niigata Prefecture; Dr. Koji Tamakoshi, Nagoya University Graduate School of Health Science; Dr. Kenji Wakai, Nagoya University Graduate School of Medicine; Dr. Shinkan Tokudome, National Institute of Health and Nutrition; Dr. Koji Suzuki, Fujita Health University School of Health Sciences; Drs. Shuji Hashimoto and Hiroshi Yatsuya, Fujita Health University School of Medicine; Dr. Shogo Kikuchi, Aichi Medical University School of Medicine; Dr. Yasuhiko Wada, Faculty of Nutrition, University of Kochi; Dr. Takashi Kawamura, Kyoto University Health Service; Dr. Yoshiyuki Watanabe, Kyoto Prefectural University of Medicine Graduate School of Medical Science; Dr. Kotaro Ozasa, Radiation Effects Research Foundation; Dr. Tsuneharu Miki, Kyoto Prefectural University of Medicine Graduate School of Medical Science; Dr. Chigusa Date, School of Human Science and Environment, University of Hyogo; Dr. Kiyomi Sakata, Iwate Medical University; Dr. Yoichi Kurozawa, Tottori University Faculty of Medicine; Drs. Takesumi Yoshimura and Yoshihisa Fujino,

University of Occupational and Environmental Health; Dr. Akira Shibata, Kurume University; Dr. Naoyuki Okamoto, Kanagawa Cancer Center; and Dr. Hideo Shio, Long-Term Care Health Facility Caretown Minamikusatu, Shiga.

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Table 1. Baseline characteristics according to green tea consumption in 21,791 men and 30,671 women.

	Green tea consumption, cups/day				<i>P</i> Value
	Never	≤2cups/day	3-4cups/day	≥5cups/day	
<b>Men, n</b>	1539	5552	5189	9511	
Age at baseline, years	57.4	55.7	57.6	58.5	<.0001
Current smokers, %	49.4	52.7	50.4	54.1	<.0001
Current drinkers, %	70.2	76.0	76.8	74.5	<.0001
Body mass index, kg/m <sup>2</sup>	22.6	22.6	22.6	22.6	<.0001
College or higher education, %	17.0	21.5	21.1	19.3	.001
Fish intake, g/day	41.8	45.9	45.4	48.9	<.0001
Vegetable intake, g/day	82.6	87.7	89.0	94.4	<.0001
Meat intake, g/day	27.0	29.0	28.9	30.0	<.0001
Bean product intake, g/day	33.8	35.3	35.7	36.8	<.0001
Energy intake, kcal/day	1596	1657	1668	1783	<.0001
<b>Women, n</b>	2620	7344	7923	12784	
Age at baseline, years	57.5	56.3	56.3	58.6	<.0001
Current smokers, %	6.6	6.1	4.3	5.2	<.0001
Current drinkers, %	21.6	26.7	25.2	23.3	<.0001
Body mass index, kg/m <sup>2</sup>	22.8	22.8	22.6	22.8	<.0001
College or higher education, %	9.5	11.1	11.8	10.9	<.0001
Fish intake, g/day	43.4	45.2	46.2	49.7	<.0001
Vegetable intake, g/day	96.2	99.1	102.2	106.2	<.0001
Meat intake, g/day	27.7	29.5	30.6	31.3	<.0001
Bean product intake, g/day	37.8	39.8	40.1	41.8	<.0001
Energy intake, kcal/day	1313	1359	1394	1447	<.0001

Table 2. Age- and sex- adjusted and area-stratified multivariate hazard ratios and 95% confidence intervals of incidence of hematologic malignancies according to green tea consumption.

	Green tea consumption, cups/day				P Value for Trend	Any drinker <sup>2</sup>
	Never	≤2cups/day	3-4cups/day	≥5cups/day		
<b>Person-years</b>	50,853	166,358	158,215	294,250		618,823
<b>Number of persons</b>	4,159	12,896	13,112	22,295		48,303
<b>Total hematologic neoplasms</b>						
No. of cases	31	69	78	145		292
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.65 (0.42-0.99)	0.73 (0.47-1.13)	0.63 (0.42-0.96)	0.63	0.66 (0.45-0.98)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.65 (0.42-1.00)	0.73 (0.47-1.13)	0.63 (0.42-0.96)	0.64	0.66 (0.45-0.98)
<b>Lymphoid neoplasms</b>						
No. of cases	19	49	56	95		200
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.78 (0.46-1.34)	0.86 (0.50-1.48)	0.69 (0.41-1.16)	0.69	0.76 (0.47-1.25)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.79 (0.46-1.35)	0.86 (0.50-1.49)	0.70 (0.41-1.19)	0.77	0.77 (0.47-1.27)
<b>Hodgkin lymphomas</b>						
No. of cases	0	3	2	3		8
Age- and sex- adjusted, area- stratified HR (95%CI)	-	-	-	-	-	-
Multivariate <sup>1</sup> HR (95%CI)	-	-	-	-	-	-
<b>Non-Hodgkin lymphomas</b>						
No. of cases	19	46	54	92		192
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.74 (0.43-1.28)	0.85 (0.49-1.46)	0.68 (0.40-1.16)	0.78	0.75 (0.46-1.22)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.75 (0.44-1.30)	0.85 (0.49-1.47)	0.70 (0.41-1.19)	0.86	0.76 (0.46-1.24)
<b>B cell non-Hodgkin lymphomas</b>						
No. of cases	10	27	25	46		98
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.76 (0.36-1.58)	0.69 (0.32-1.48)	0.59 (0.29-1.23)	0.52	0.68 (0.34-1.34)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.74 (0.35-1.54)	0.66 (0.31-1.42)	0.58 (0.28-1.20)	0.51	0.65 (0.33-1.30)
<b>T/NK cell non-Hodgkin lymphomas</b>						
No. of cases	1	1	3	5		9
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.32 (0.02-5.18)	0.97 (0.10-9.71)	0.73 (0.08-6.72)	0.61	0.66 (0.08-5.45)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.24 (0.01-4.86)	1.12 (0.09-13.32)	0.90 (0.08-9.87)	0.91	0.70 (0.08-6.62)
<b>Non-Hodgkin lymphomas, NOS</b>						
No. of cases	8	17	25	38		80
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.72 (0.31-1.69)	0.96 (0.42-2.20)	0.71 (0.32-1.60)	0.84	0.78 (0.37-1.67)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.76 (0.32-1.79)	1.01 (0.44-2.32)	0.76 (0.34-1.73)	0.72	0.83 (0.39-1.78)
<b>Acute lymphoid leukemias</b>						
No. of cases	0	1	1	3		5
Age- and sex- adjusted, area- stratified HR (95%CI)	-	-	-	-	-	-
Multivariate <sup>1</sup> HR (95%CI)	-	-	-	-	-	-
<b>Follicular lymphomas</b>						
No. of cases	2	2	2	4		8
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.19 (0.03-1.38)	0.22 (0.03-1.71)	0.19 (0.03-1.21)	0.69	0.20 (0.04-1.01)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.16 (0.02-1.27)	0.15 (0.02-1.32)	0.14 (0.02-0.99)	0.71	0.15 (0.03-0.88)
<b>Diffuse large B cell lymphomas</b>						
No. of cases	2	4	4	6		14
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.53 (0.10-2.98)	0.62 (0.11-3.59)	0.47 (0.09-2.49)	0.90	0.53 (0.12-2.41)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.53 (0.09-3.09)	0.71 (0.12-4.27)	0.49 (0.09-2.71)	0.91	0.55 (0.12-2.62)
<b>Plasma cell neoplasms</b>						
No. of cases	4	19	15	29		63
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	1.47 (0.49-4.39)	1.12 (0.36-3.50)	1.03 (0.34-3.10)	0.39	1.22 (0.43-3.48)
Multivariate <sup>1</sup> HR (95%CI)	1.0	1.36 (0.46-4.08)	1.03 (0.33-3.22)	0.95 (0.31-2.87)	0.33	1.13 (0.39-3.22)
<b>Chronic lymphocytic leukemia/small lymphocytic lymphomas</b>						
No. of cases	2	0	0	4		4
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	-	-	-	-	0.12 (0.02-0.81)
Multivariate <sup>1</sup> HR (95%CI)	1.0	-	-	-	-	0.09 (0.01-0.96)
<b>Myeloid neoplasms</b>						
No. of cases	10	19	20	46		85
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.50 (0.23-1.08)	0.58 (0.26-1.30)	0.59 (0.28-1.25)	0.91	0.55 (0.27-1.10)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.49 (0.23-1.08)	0.58 (0.26-1.30)	0.58 (0.27-1.24)	0.83	0.54 (0.27-1.10)
<b>Acute myeloid leukemias</b>						
No. of cases	7	9	10	22		41
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.32 (0.12-0.89)	0.35 (0.13-0.98)	0.35 (0.14-0.90)	0.41	0.34 (0.15-0.81)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.33 (0.12-0.92)	0.37 (0.13-1.04)	0.35 (0.14-0.92)	0.36	0.35 (0.15-0.84)
<b>Chronic myeloid leukemias</b>						
No. of cases	0	2	3	5		10
Age- and sex- adjusted, area- stratified HR (95%CI)	-	-	-	-	-	-
Multivariate <sup>1</sup> HR (95%CI)	-	-	-	-	-	-
<b>Myelodysplastic syndromes</b>						
No. of cases	3	8	6	17		31
Age- and sex- adjusted, area- stratified HR (95%CI)	1.0	0.75 (0.20-2.87)	0.69 (0.16-2.99)	0.86 (0.23-3.28)	0.89	0.78 (0.22-2.68)
Multivariate <sup>1</sup> HR (95%CI)	1.0	0.69 (0.18-2.68)	0.63 (0.15-2.75)	0.81 (0.21-3.14)	0.86	0.72 (0.21-2.50)

1Multivariate model included age, sex, education level, cigarette smoking, alcohol intake, body mass index, fish intake, vegetable intake, meat intake, bean products intake, and energy intake.

2Categories of green tea consumers of ≥1 cup/month of green tea (i.e. 1cup/month-2cups/day, 3-4 cups/day, and ≥5 cups/day)