Cancer Research Center of Hawai'i
UNIVERSITY OF HAWAI'I

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Multiethnic Bulletin

A NEWSLETTER FOR THE PARTICIPANTS IN THE MULTIETHNIC COHORT STUDY

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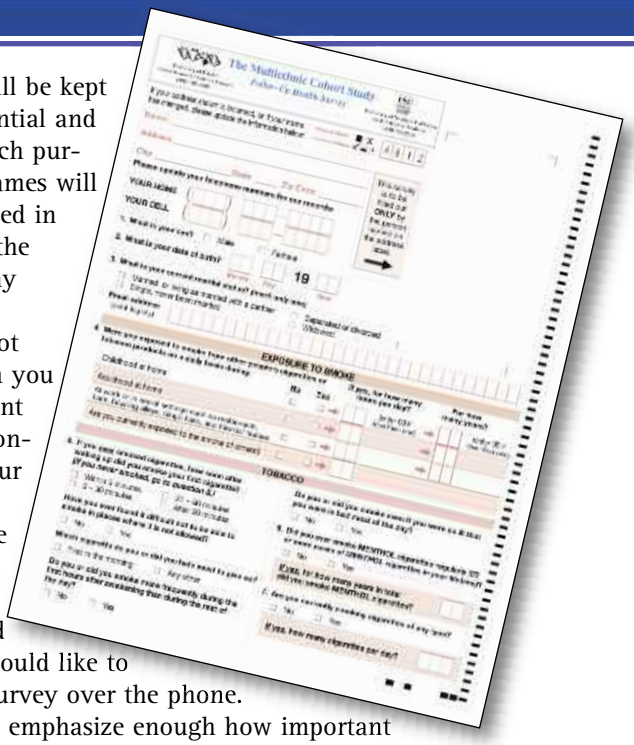
Multiethnic Cohort Update

After many months of careful development, we have prepared a new, four-page ***Follow-Up Health Survey.*** The survey is being mailed to all members of the **Multiethnic Cohort Study (MEC)** who completed the very first questionnaire in 1993-1996. We ask for your valuable help in completing and returning this newest survey. It's been more than 15 years since you helped us the first time. In the intervening years, most of you have also completed additional questionnaires, and many of you have provided laboratory specimens for our research.

A cohort study such as the MEC follows individuals over time to see who develops cancer, to identify possible causes of this disease, and to determine why some individuals are more susceptible to cancer than others. That is why we ask you for updated information from time to time and why no one else can take your place. Our goal is to reduce people's risk of getting cancer.

The mailings of the ***Follow-Up Health Survey*** will occur in 4 phases between now and 2012. So don't be concerned if your form has not yet arrived in the mail. In this survey, we ask about your exposure to smoke from other people's tobacco usage, your own use of tobacco, your recent physical activity, your use of vitamins, and health-related conditions you may have developed. As always, all information you provide will be kept totally confidential and used for research purposes only. Names will not be associated in any way with the reporting of any research data.



If we do not hear back from you after having sent you the questionnaire, one of our friendly interviewers may be calling to find out if you received it, and whether you would like to complete the survey over the phone.

We cannot emphasize enough how important your continued participation is to the success of the study, and to the field of cancer research. We kindly urge you to mail back your completed survey within a short time after receiving it. That way, we can avoid postage expenses for repeated mailings. **For information on the MEC study, please visit our website at *www.crch.org/multiethniccohort.*** ❖

A New Study Will Help Improve the MEC Diet Questionnaire

As participants of the *Multiethnic Cohort Study* (MEC), all of you filled out a lengthy diet questionnaire when you enrolled in the study in 1993-1996. Most of you also filled out a second detailed diet questionnaire about 10 years later, so that we could determine any changes in your diet. In addition, at the time of the first questionnaire, about 1,570 of you helped us with a special study to make sure that the questionnaire provided accurate information about food intakes.

*Interviewers, **Kathy Price** (left) and **Jean Ishida** (right) are currently recruiting participants for the calibration study.*

This special study was a *24-hour dietary recall,* which required persons to report to a telephone interviewer everything they had eaten the previous day on three separate occasions. We then compared the more precise information from the *24-hour dietary recalls* with the information from the questionnaires. Studies such as this one that compare two methods of collecting dietary [continued on page 3]

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Explaining the Large Ethnic Differences in Bladder Cancer Risk Among Participants in the Multiethnic Cohort Study (MEC)

Official estimates predict that there will be 70,530 new cases of bladder cancer and 14,680 deaths from bladder cancer in the U.S. in 2010.

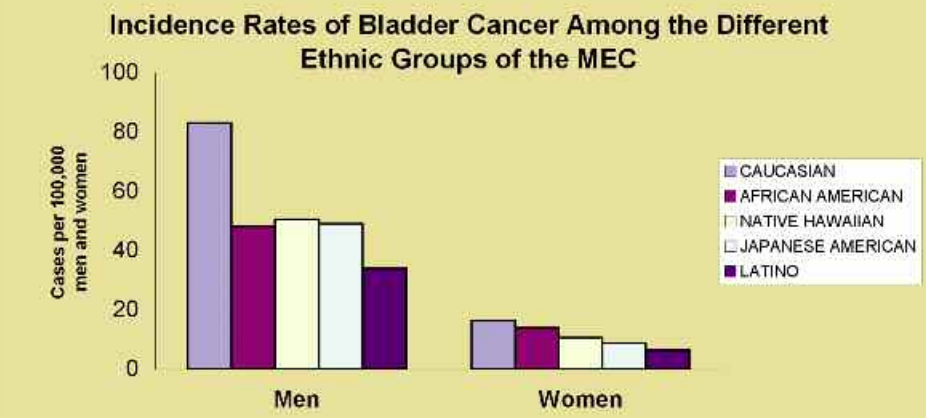
Cigarette smoking is known to be the most important cause of bladder cancer in the general population. However, not much research has been done to compare the incidence of bladder cancer across different ethnic or racial groups. And no studies have been done to see whether the ethnic differences in bladder cancer rates are simply due to variations in smoking among these groups.

To investigate these questions, we analyzed the data on bladder cancer incidence among participants in the MEC in relation to their smoking habits. We obtained the information on smoking from the questionnaire that more than 200,000 of you completed when you first joined the study in 1993-1996. After 11 years in the study, nearly 1,000 MEC participants had been diagnosed with bladder cancer.

There are five main ethnic/racial populations in the MEC: African Americans, Japanese Americans, Latinos, Native Hawaiians, and Caucasians. We found that cigarette smoking was strongly associated with the risk of bladder cancer in all five ethnic groups, both for men and for women.

However, the incidence rates for bladder cancer were quite different among the five ethnic populations, with the risk being much higher in Caucasians than in the other groups. Surprisingly, we did not find that these variations in risk were due to different rates or amounts of smoking in the ethnic groups. In future studies, we will need to look for other explanations, such as ethnic differences in *susceptibility* to the effects of smoking.

We also found that even though African American and Latino women had lower incidence rates of bladder cancer compared to Caucasian women, they tended to be diagnosed at a more advanced stage, when treatment is generally less successful. Reasons for these differences also need to be investigated further.



Caucasian men and women in the MEC have the highest rate of bladder cancer while Latinos have the lowest.

Thus, using the unique populations in the MEC, we have been able to confirm the importance of cigarette smoking as a major cause of bladder cancer in each of our ethnic populations. Although all of the variation in bladder cancer among these groups isn't explained by smoking alone, these results emphasize that the prevention of cigarette smoking and the continued encouragement of current smokers to quit are important ways to decrease a person's chance of getting bladder cancer (as well as several other important cancers that are related to smoking, such as lung cancer). ❖

SURVEY DATA

BASED ON SURVEY DATA THAT YOU REPORTED UPON JOINING THE STUDY

Curious Facts

- The birthday shared by most MEC participants is January 1. The second most common birthday is May 5.
- 55% of study participants have smoked at some time during their lives.
- At present, the youngest participant in the study is 56 years old; 99.5% of the MEC participants are now 60 years or older.
- 44% of the study participants have 2-3 children.
- 10% of the study participants sleep fewer than 5 hours per night on average; 33% sleep 8 hours or more.
- 90% of women in the study have had a least one mammogram.
- 42.9% of study participants reported having either a parent or sibling who had cancer. ❖

Coenzyme Q10 and Breast Cancer

Coenzyme Q10 (CoQ_{10}) is produced in all tissues of the body, and is essential for the production of energy. The ability of our cells to make this important molecule declines with age, however, and some scientists have wondered whether decreased levels of CoQ_{10} in tissues may accelerate the development of some of the diseases that come with aging, like cancer.

Although CoQ_{10} supplements have been shown to have certain benefits (for example, they can improve heart function in individuals with congestive heart failure), the benefits (or risks) of taking CoQ_{10} supplements to prevent or treat *cancer* have not been established.

We were particularly interested in studying the effects of CoQ_{10} on breast cancer in the *Multiethnic Cohort Study* (MEC). Using the blood samples that many of you had donated several years ago, we were able to examine the relationship between levels of CoQ_{10} in the blood and the risk of developing breast cancer. We found that women with higher levels of CoQ_{10} in their blood may be at higher risk of developing this cancer.

One interpretation of this finding is that individuals with higher levels of CoQ_{10} in the blood may be experiencing more damage in their tissues. When tissues undergo damage, they release more CoQ_{10} into the blood stream, leaving lower levels of this important molecule behind in the cells. While this possible explanation is not yet proven, it is an exciting area for our future research. From such studies as these in the MEC, we may be able to identify high-risk individuals who can benefit from special supplements like CoQ_{10}. ❖

A New Study Will Help Improve the MEC Diet Questionnaire

[continued from page 1]

data are often called "calibration" studies. We found that intakes using the two methods were very similar.

Because foods in the marketplace had changed since the MEC was started, the second detailed diet questionnaire had to undergo some changes and, therefore, was not identical to the first one. Furthermore, the methods for conducting 24-hour recalls have changed since our last calibration study. For these reasons, we are now doing another calibration study to test the accuracy of the second questionnaire. For this study, we are asking the participants to complete the revised diet questionnaire, and to do three *24-hour dietary recalls*.

Two of our interviewers are currently recruiting 300 participants (30 men and 30 women from each of the five main ethnic groups in the MEC: African Americans, Japanese Americans, Latinos, Native Hawaiians, and Caucasians). As in the previous calibration study, the *24-hour dietary recalls* are done by telephone. No blood or urine samples are being collected.

Recently, a new method was developed to enable persons with internet access to complete *24-hour dietary recalls* without speaking to an interviewer on the telephone. This new method is called the *Automated Self-Administered 24-Hour Dietary Recall* (ASA24). We are asking participants in the new calibration study to also do the ASA24 if possible. With their help, we will evaluate this system as a possible method for us to collect dietary data in future studies.

At the present time, we have recruited almost 100 of the 300 participants needed for this second calibration study. If we contact you, we hope you will agree to help as we try to improve our diet questionnaire. We will share the results with you when the study is completed in approximately two years.

We greatly appreciate the efforts that our MEC participants make to help us in our research into the role of diet as a major risk factor for cancer and other chronic diseases. ❖

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Multiethnic Cohort Study
1236 Lauhala Street, Room 407
Honolulu, Hawai'i 96813

ADDRESS SERVICE REQUESTED

RECIPE FOR HEALTHY LIVING

HEARTY MINESTRONE

INGREDIENTS:

2 tablespoons olive oil
1 1/3 cups (2 medium) onions, coarsely chopped
1½ tablespoons (4 medium) garlic cloves, minced
1 cup (2 medium) carrots, peeled and sliced
1 15-ounce can low-sodium chicken or vegetable broth
1 28-ounce can tomatoes, chopped
1 teaspoon dried thyme
¼ cup chopped fresh parsley
2 cups chopped frozen spinach, kale, or collard greens, thawed
1 cup frozen corn, thawed
2 cups cooked white northern beans
2 cups cooked pasta (such as macaroni), whole wheat or white
1 teaspoon salt or to taste
pepper to taste

Heat the oil in a large pot and sauté the onions, garlic, and carrots for 4 to 5 minutes, or until the onions are soft and translucent. Add the broth, canned tomatoes with their juice, thyme, and parsley and simmer covered for 5 to 6 minutes. Add the greens and corn and continue to simmer for 5 to 6 minutes, or until all of the vegetables are cooked. Add the beans, pasta, salt, and pepper to taste. Heat through until the soup is warm but not boiling, adding more liquid as needed.
Makes 12 (1 cup) servings.

NUTRITION INFORMATION
(Per 1 cup serving)

Calories	130
Protein (g)	7
Fat (g)	3
Saturated Fat (g)	0
Carbohydrate (g)	21
Fiber (g)	5
Cholesterol (mg)	0
Sodium (mg)	330

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1450 Biggy Street, NRT 1502
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