after the ban provides strong evidence for reduced inhalation of secondhand smoke in the same period, as does the bar workers’ self-reported estimate.

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Green Tea Consumption and Mortality in Japan

To the Editor: The study of green tea consumption and mortality by Dr Kuriyama and colleagues1 concluded that green tea consumption is associated with reduced mortality due to all causes and due to cardiovascular disease but not with reduced mortality due to cancer. I believe that these conclusions can only be made for consumption of 100 to 500 mL/d of the green teas purchased in northeastern Japan.

Pharmacodynamic data from the National Cancer Institute indicate that for a 70-kg person, consumption of 800 mL (4 cups) of green tea that contains 710 µg/mL of (−)-epigallocatechin gallate would be required to be comparable with the lowest effective anticancer dose in animal model studies.2 There is evidence of green tea as a cancer preventive for humans in other parts of Japan where quality green teas, “typical” as defined by the National Cancer Institute, are traditionally consumed.3,4 Because amount of tea consumption and type of green tea may vary in other areas, the findings of Kuriyama et al must not be extrapolated beyond their regional significance.

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In Reply: Our study found a statistically nonsignificant increase in the risk of cancer death among participants who consumed 5 or more cups of green tea per day compared with participants who drank less than 1 cup per day, with a hazard ratio of 1.11 (95% confidence interval, 0.90-1.36) in men and 1.07 (95% confidence interval, 0.80-1.44) in women. We were unable to divide this highest category of consumption into subcategories, such as 10 or more cups/d and 5 to 9 cups/d, because these subcategories were not included on the questionnaire completed by the participants.

Dr Lee argues that our lack of inverse results might be partly explained by the categories we used, citing 3 articles1-3 as evidence that the risk of cancer decreases only with very high consumption of green tea. However, one of these articles reports the results of animal models, and such findings are not always replicated in humans. The other articles2,3 are reviews that discuss a single cohort study with 8552 participants.7 Although the study of this cohort did include a category representing very high consumption of 10 cups/d or more and found a significantly decreased risk of cancer, the study had several methodological limitations, including a relatively small sample size, no information about disease history in the participants (which could result in a bias due to healthier participants drinking more green tea), and no documentation of the validity of the questionnaires used to measure consumption of green tea.

Lee also suggests that our null results were due partly to regional characteristics, where people do not have easy access to “typical” green tea. This is inaccurate. Miyagi Prefecture is located in the central part of the Tohoku region, 300 km northeast of the capital, Tokyo. Although agriculture is one of the main industries, Miyagi Prefecture is also one of the most industrialized and commercialized areas in Japan. Consumers are mobile and shop in broader regions. As the distribution of merchandise is highly efficient in Japan, residents of Miyagi consume high-grade green tea as in other areas of Japan. The mean household expense for green tea per year among persons living in Sendai City, Miyagi Prefecture, from 2003 to 2005 was 5314 Japanese yen, comparable to the national average of 5763 Japanese yen.8

Although data on the association between green tea consumption and overall cancer risk are scarce, almost all prospective studies of green tea consumption and the risk of cancers at individual sites have shown no relationship.6,7 Among them, Hoshiyama et al9 found no significant association between green tea consumption and stomach cancer risk among nationwide participants in Japan, even when a category of very high consumption of 10 cups/d or more was included.

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Psoriasis and Risk of Myocardial Infarction

To the Editor: The prospective cohort study by Dr Gelfand and colleagues found that patients with psoriasis had an increased adjusted relative risk for myocardial infarction (MI). In their conclusion, the authors state that psoriasis may confer an independent risk of MI, which is greater in young patients with severe psoriasis. Analyses were performed using conditional logistic regression, adjusted for age, sex, and other major cardiovascular risk factors (hypertension, diabetes, history of MI, hyperlipidemia, smoking, and body mass index).

Other studies have demonstrated the association of psoriasis with severe psychological morbidity, in particular with depression. Devrimci-Ozguven et al demonstrated that patients with psoriasis had significantly higher degrees of depression and more body cathexis problems than did patients with psoriasis. In addition, profound psychological morbidity (particularly with depression) in a large number of patients. In addition, depression is an independent risk factor for coronary heart disease and an aggravating factor for preexisting cardiovascular disease. Moreover, disease-related psychological stress has been associated with an increased risk for coronary artery disease.

It therefore seems that several influencing and confounding factors, such as depression, psychological disorders, and disease-related stress, could have biased the findings of Gelfand et al. We believe that adjustment for these factors would result in a more accurate estimation of the actual additional risk of MI in patients with psoriasis.

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To the Editor: Dr Gelfand and colleagues studied the risk of MI in patients with psoriasis. The authors found that psoriasis is an independent risk factor for MI, especially for young patients with severe disease, and hypothesized that exaggerated immune activity could lead to a higher risk for MI by linking Th1 diseases to atherosclerosis and coronary artery disease. However, the exact mechanism by which Th1-mediated diseases predispose patients to vascular disease remains unclear.

The study by Wakkee et al reviewed the mechanisms by which systemic inflammation results in an adverse effect on the cardiovascular risk profile in patients with psoriasis: oxidative stress, endothelial cell dysfunction, hyperhomocysteinemia, and platelet adhesion, together with well-known risk factors for MI such as hypertension and dyslipidemia. We have observed a higher prevalence of hyperhomocysteinemia in patients with psoriasis compared with healthy patients, and an inverse association between severity of psoriasis and plasma folate acid levels. Folate deficiency in patients with psoriasis could be due to an increased loss of folate acid (by rapid skin turnover) and reduced absorption from the intestine.

Hyperhomocysteinemia is an independent risk factor for coronary artery disease, stroke, and peripheral vascular disease. We have also found that hyperhomocysteinemia is directly associated with the Psoriasis Area and Severity Index, suggesting a potential explanation for the higher risk